FINAL EVALUATION REPORT - PHASE 4 Feb 1976 - June 1978

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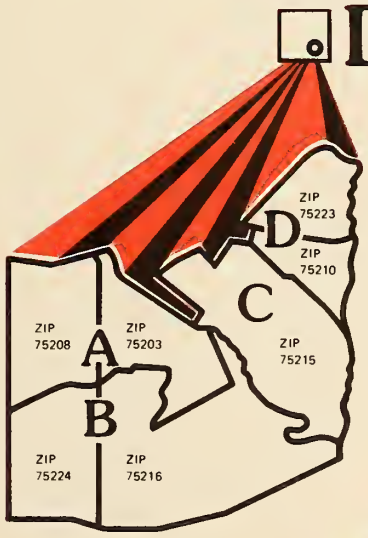
EPSDT Demonstration in an Urban Setting Dallas, Texas



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FINAL EVALUATION REPORT
(Phase 4)

September 15, 1978

EPSDT IN AN URBAN SETTING - DALLAS, TEXAS

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PREFACE

The Dallas Project in Broad Perspective

This project has effectively demonstrated methods and related costs necessary to involve increasingly larger proportions of an eligible urban population in the EPSDT program, and achieve high rates of treatment for problems found. Appropriate case finding, screening, and case monitoring models are suggested in this report.

In accomplishing these project objectives, clear parameters are established for policy makers and program managers to determine the extent of effort and associated costs required to achieve various levels of participation and treatment. The project has also identified realistic upper levels of potential program participation and treatment as a foundation for future realistic program objectives.

Notwithstanding these results, there is a rising tide of questions within state governments and the professional health community concerning this preventive health program that has yet to be proven wholly cost beneficial. EPSDT exists on a presumption of cost and health beneficence. The scientific literature does not provide direct conclusive evidence to this end. The State of California, for example, for this reason commissioned this Institute to develop a prospective longitudinal study design to test the validity of the presumption, which is currently under consideration. In the interim, on the assumption that sufficient longitudinal data may now exist in some communities on the EPSDT and similar programs (C & Y), some retrospective studies of the impact of the program on the health of children have been proposed. These studies, both prospective and retrospective, need to be done.

Though the foregoing challenges primarily address the large issue of generalized preventive health screening programs for children, this report also raises questions* concerning the current operational configuration of EPSDT itself, e.g., the value of certain screening tests; the value of any programmatic data without adequate and commonly utilized definitions, standards, and quality assurance measures; and the value of case finding all eligibles and case monitoring all problems. Changes suggested by this report offer the possibility of certain programmatic cost savings.

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*These questions arise not only from the Dallas project, but are a synthesization of the Institute's total experience with EPSDT over the past five years, including five other demonstration projects, three surveys of the program in fifteen states, frequent contact with program operators, exposure to other reports and studies in the subject area,and in-depth review of the literature in the area of child health assessments in general.

There is a need, and now appears to be the time, for re-examination of the program. There has now been developed a sufficient body of experience with this unprecedented preventive health program for children to accomplish a penetrating review. The EPSDT program was established in a context in which the poor had neither sufficient financial resources nor adequate knowledge of how to enter the health care system to obtain sick care, much less preventive care. However, in the thirteen years since enactment of the Medicaid legislation (1965), the categorical poor (and also the EPSDT eligibles) have gained financial access to care, and there are now indications that they are learning to utilize the available* local health care resources to obtain acute care.

The significance of the program now seems to lie more clearly in its preventive thrust, and both the poor and the non-poor segments of the American public appear to be under-utilizing opportunities to obtain personal preventive health care. It is for these reasons that a review of the principles surrounding "case finding" and "case monitoring" appears appropriate.

Prioritization of case finding (to high risk [very young] unmarried mothers and their children, for example) and case monitoring (to severe problems and problems not having reached treatment after a prescribed time interval, such as 45 days, for example) may serve to give the program a more meaningful and acceptable focus in the current time frame. This, of course, presupposes the existence of EPSDT management information systems to provide the basic case monitoring data.

Additionally, we have become increasingly aware of the major "de facto" models by which states structure to provide EPSDT services, i.e., (1) public sector screening/private sector treatment, (2) private sector screening/treatment, and (3) combinations of these in parallel. These major models have distinct and oftentimes unique operational and systems characteristics. There are highly acceptable examples of all three major models and many other examples of marginal and unacceptable programs in these modes. Objective evaluation of these "good" models needs to be accomplished, analyzed and the resultant recommended "models" widely disseminated by HCFA for emulation.

The current legislative thrust to reinforce the EPSDT program by improved legislation is especially important with respect to increased Federal matching rates for both Medicaid and administrative costs, but HCFA needs to continue to evaluate and refine the program guidelines within a prioritization of effort framework suggested by the findings of this and other related reports.

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*These may not always be the most appropriate or desirable sources of care, but major revision of the health care delivery systems in the United States is a problem requiring long range solutions and not perhaps within the purview of the EPSDT program, per se.

SUMMARY - PART I

The Demonstration

Project Background and Purpose

At the time this project was being conceptualized in early 1975, EPSDT nationally was in its third year of operational implementation. The EPSDT program had, by then, realized only approximately 20 percent participation in the program out of some 10.3 million eligibles. The general methods of outreach (case finding) then employed by most of the states were program notification at the time of welfare application or recertification, follow-up form letters at time of certification and other standardized intervals, or flyers enclosed with welfare checks. Broken screening appointments most frequently ranged in the area of 60-75 percent of those made. A survey of treatment follow-up of conditions found in EPSDT screening conducted in the same time frame in a sample of states indicated that only approximately 46 percent of the problems reached treatment.* In most instances, no formal case monitoring (follow-up) system had been established, and in other instances the function of case monitoring, per se, had not been delineated or assigned to a specific department or agency. Case monitoring, when accomplished, was only required to substantiate "show for treatment" (a kept appointment) without regard to treatment completion. Case finding and case monitoring functions of EPSDT, when done at all, were generally superimposed as additional functions upon welfare workers (social workers) already heavily tasked.

Program participation was lagging, particularly in the 14 major urban complexes of the country, such as Cleveland, Philadelphia, Los Angeles, and New York, where approximately 64 percent of the program eligible children were located.

Since these methods, or lack of them, did not appear to offer any greater potential for program participation than that indicated above, if the program was to achieve the full participation and high rate of treatment expected by the Congress**, new methods of case finding (outreach) and case monitoring (follow-up) needed to be demonstrated to stimulate improvement in the EPSDT programs in urban centers of the various states. This was the objective of the Dallas project--"EPSDT Demonstration in an Urban Setting".

*Social and Rehabilitation Services, DHEW-Information Memorandum MSA-1M-74-11; (key findings): Study of the EPSDT Program, 1974.

**U.S. Congress: Report by the Sub-Committee on Oversight and Investigation of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninety-Fourth Congress, Second Session, "Department of Health, Education and Welfare's Administration of Health Programs: Shortchanging Children", September, 1976.

The purpose of this three year project (1975-1978) was to demonstrate, in an urban setting, methods and associated costs that would significantly increase EPSDT program participation and treatment of problems found in screening.

Methodology/Organization

A seven zip code area of Dallas was divided into four sectors: three for testing various case finding and follow-up methods, and the fourth for utilizing the ongoing program methods, and, thus, serve as a comparison. The project area included 13,700 eligible children, 95 percent of whom were Black.

A total case management system, from identification of eligibles through family contact, to screening and treatment completion, including forms, automatic data processing (ADP), case control rosters, etc., was established and is detailed in Chapter V. Screening clinics in support of the project were located generally an average of 2.5 miles from client homes and were operated by the City of Dallas Health Department. Treatment of conditions found in screening was most often by referral to private sector health practitioners, including centralized hospital clinics.* The project time span was divided into four phases, generally of six months duration, in which varying techniques of case finding/case monitoring were employed.

Case Finding and Case Monitoring Methods Tested

The methods of case finding and case monitoring tested during the evaluation of the project were as follows:

Case Finding

- Home visit contact of designated eligibles by case finders of varying skill categories and varying time commitment assignments, either full time or time split between functions of case finding and case monitoring.
- A series of contacts to designated eligibles consisting of first, mailing up to three letters; second, phone calls to non-respondents to the letters; and third, in-home contact of those not responding affirmatively to the first two efforts by DPW social workers (Public Welfare Workers) functioning both as case finders and case monitors.
- Specialized EPSDT clinics for teenagers to determine the impact on their participation in the program.
- A six-fold increase in screening site availability (neighborhood clinics) to determine the impact on participation in the program.

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*This separation of screening and treatment between the public and private sectors of health is frequently referred to as the two step "EPSDT model". It is the most common pattern found in state EPSDT programs. The "one step" model is generally patterned on the private sector physician executing both screening and treatment.

- In-home screening of clients unsuccessfully recruited by other techniques to ascertain the maximum level of attainable voluntary program participation, and the cost.

Case Monitoring

- A structured case monitoring system was introduced which included forms, client/provider feedback, ADP, case management rosters, and home visit contact of clients by full time and split time case monitors of varying skill categories.

- Incompleted immunizations were designated as conditions for follow-up by case monitors in a similar context to incomplete problems.

- Eligible individuals with problems received case monitoring assistance through treatment completion (extended follow-up) as contrasted to follow-up to show for treatment (limited follow-up).

Results and Discussion

The results of the first three phases of project activity were previously reported in detail.* The more significant findings of those earlier phases and this final (fourth) phase are as follows:

Case Finding:

- The home visit contact of program eligibles by trained indigenous community service aides produced rates of kept appointments for screening of 34 percent with one appointment effort; 48 percent with two appointment efforts; and 51 percent with three appointment efforts (Report #2).

- Case finders/monitors are most effective if culturally/ethnically identified with the main body of eligibles (Report #4).**

- Case finding/monitoring through contract with community organizations is highly effective in communities in which there are large enclaves of recent immigrants with a major ethnic/cultural identification ** (Mexican Americans, Cuban Americans, Puerto Ricans). (Report #4)

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* Phase 1, February-June, 1976, dated November 15, 1976
Phase 2, February-December 1976, dated May 15, 1977
Phase 3, February 1976-June 1977, dated November 15, 1977

** Based upon a comparison with the Inman Christian Center, San Antonio, Texas as a part of the COMPASS variable in this report.

.. Contact of designated program eligibles by welfare workers using the sequential approach of multiple letters (up to three), phone calls to non-respondents, and, finally, in-home contact of those not responding to the first two efforts produced rates of kept appointments for screening of approximately 43 percent. It is expected that this approach would have also achieved approximately 50 percent show for screening rate if carried to the full extent of three efforts to achieve a successful appointment as the home visit method. (Report #2)

.. Actively increasing the availability and accessibility of screening sites (to within eight to ten blocks of homes-neighborhood clinics) by using mobile screening teams in community donated space (churches, clubs, recreational rooms, parks, etc.), while holding relatively constant the home visit outreach techniques, increased the "kept appointment" rate from 51 percent to 84 percent (with up to three appointment efforts), and the program participation rate from 50 percent to 60 percent (Reports #3 and 4) with an estimated potential of a 70 percent program participation rate.

.. The neighborhood clinics served as a means to overcome the often reported programmatic barriers to program participation, e.g., transportation and clinic waiting time (Reports 3 & 4 [Appendix A, Chapter 2]).

.. The mode of case finding/screening that may be expected to produce the highest rates of participation in an EPSDT program in a two step configuration in an urban setting at the most efficacious cost is: (Reports 2, 3, and 4)

- case finding aides* indigenous to the target population area (either as contract or public sectors employees);
- family contact to recruit EPSDT participation by a home visit (face-to-face contact);

Or (Equal Option)

- family contact through a series of contact efforts consisting first of a mailing of up to three letters; second, phone calls to non-respondents to the letters; and third, in-home contact of those not responding affirmative to the first two efforts;

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*Functioning as joint case finders/monitors.

- screening sites (neighborhood clinics) highly accessable to the target families, generally within 10 blocks of homes;
- transportation that is highly responsive to client needs, generally under operational (dispatch) control of the respective clinics;
- single management (or operational control) at the local level of the outreach (case finding), transportation and screening activities relating to an EPSDT screening;
- parent participation to the maximum extent feasible in the screening process itself, and in the evaluation of the results (nurse or doctor/parent consultation).

This mode of EPSDT case finding/screening should be expected to produce program acceptance rates of 98 percent by families contacted and "kept appointment" rates for screening in the range of 80-90 percent at a case finding cost of $25.00 - $30.00 per child screened (including transportation) and screening costs of $20.00 - $25.00 per child screened.

. . The maximum level of program participation in EPSDT in an urban setting that appears feasible in the voluntary context even with this optimum mode of case finding/screening is approximately 75 percent. This is due to the finding that it is possible to contact at a maximum only approximately 90 percent of eligible families because of frequency of family moves (changes in address), rapid changes in eligibility status, and other unavailability of the parent for contact (Report #4). Also, of those families contacted by most of the demonstrated methods of case finding, approximately only 92 percent were willing to participate in the program (Report #3). In the optimum mode, however, as high as 98 percent agreed to participate (Report #4). Furthermore, in the optimum mode, 85 percent of those agreeing to participate can be expected to show for screening (Report #4). The effects of these categories of constraint on program participation are illustrated with hypothetical numbers in the following table:

Categories of Constraint on Participation	Percent	Application to Hypothetical Numbers	Resultant Percentage of Eligibles
(Total Eligibles)	100%	10,000	100%
Maximum percentage of eligibles that can be successfully contacted in a voluntary mode.	90%	9,000	90%
Maximum percentage of eligibles contacted that will agree to participate	98%	8,820	88%
Maximum percentage (of program acceptors) that will show for screening*	85%	7,497	75%
(Amenable to improvement by In-Home screening)	(90%)	(7,938)	(79%)

*With up to three appointment efforts.

. . To achieve program participation by at least 50 percent of the program eligibles in an urban environment by the use of these methods requires a staffing ratio of approximately one full-time equivalent case finder per 350 eligible families, or 900 eligible children.* (Report #2). It takes a minimum average of two home visits by a case worker utilizing the in-home method of contact to establish a family contact. Frequency of moves (change in address) or unavailability of the parent (not at home) were the major factors involved in the required repeat visits. (Report #4).

. . The case finding cost per show for screen to achieve the 45-50 percent level of program participation (Sectors A & B) averaged approximately $35.00, and could be expected to range between $32.00 - $42.00 in other jurisdictions, depending upon local salary scales, etc. (this does not include any share of support for state level program infra-structure, such as state level program management and data processing).** (Report #2). This cost relates to case finding activities that achieve "kept appointment" rates in the area of 50-60 percent. In those instances, however, in which the case finding activities are so successful (Sector C) as to minimize wasted efforts (missed appointments) and produce "kept appointment" rates of 80-90 percent the case finding cost per child screened may decline as low as $25.00 (excluding infra-structure costs) in the mode reported (Report #4).

. . In-home screening is a feasible means of increasing EPSDT participation. Client response was good. The constraints imposed upon this variable and the unique success of the "neighborhood clinics" significantly limited the sample size and the statistical validity of the results. In a large scale effort in this mode, a case finding effort would be essential to assure maximum efficient use of the screening team. It is estimated that the "case finding" activity would cost approximately $30.00 per child screened. Notwithstanding, it is generally not necessary to use this mode to achieve high rates of participation if other effective means are employed (neighborhood clinics, etc.). In-home screening should only be utilized in unusual situations.

. . In-home screening of a small group of families in Sector C who had twice previously (two cycles) been contacted and had refused the service, or had repeatedly broken appointments (three to six) indicated these children, contrary to expectation, were as healthy as the children in families

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*Based upon an average 2.6 children per eligible family.

**See "Summary of Costs" this section, page 11, for estimate of infra-structure costs.

more readily participating in the program. The problem finding rate in this group of children was only 15 percent, whereas the same screening team in the mobile mode found 24.5 percent problems. The status of current immunizations in this group was also significantly higher. (Report #4).

. . A survey conducted of EPSDT "program rejectors" (complete and partial) indicates that the most difficult mothers to recruit may be the younger, least experienced parents that are single, less educated, and unemployed and who feel isolated from society. This suggests one possible approach to prioritization of case finding (Report #4--Chapter II, Appendix A).

. . Inter-agency cooperation in an informal context wherein a multitude of agencies each representing its own interests in support of children was effectively demonstrated in fashioning an EPSDT clinic for teenagers (ages 13-20). Two findings of significance emerge from this experience. One, the teen centered clinic in its limited application in this project did not appear to be the incentive to teenage participation in EPSDT anticipated; little improvement in teenage participation was demonstrated. The challenge of increased teen participation in the program still stands, and may not be significantly alterable in the current status of the American culture. Two, inter-agency cooperation to provide services in a common setting appears feasible, but real (actual) inter-agency cooperation to avoid duplication of services, wherein one agency may have to surrender a task or function impinging upon its own self interests, may be more a goal than an achievable reality. (Reports #3 and 4 [MIC]).

Case Monitoring

. . The introduction of a structured case monitoring system, which included designated case workers, referral forms, provider/client feed-back, assistance in making appointments, and provided transportation into a state utilizing public sector screening/private sector treatment increased "show for treatment" rates from 64 percent to 85 percent. (Report #3). In Texas the baseline rate of 64 percent was predicated upon existing minimal case monitoring activities and designated responsibility. State case monitoring programs, less developed than Texas' in the pre-test (baseline), have the potential for much higher rates of improvement.* (Report #3).

. . "Limited" case monitoring to "show for treatment" offers as great a potential for treatment completion in a "two-step" configuration as does "extended" case monitoring through treatment completion. Both methods of follow-up produced relatively the same rate of treatment completion (85 percent [limited follow-up]; 88 percent [extended follow-up]). (Report #3).

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*Review of Shows for Treatment - EPSDT a Nine State Survey, Health Services Research Institute, The University of Texas Health Science Center at San Antonio, March 31, 1977.

. . Representative case monitoring costs in this time period ranged between $31.00 - $40.00 per medical problem referred and immunization followed-up*, or between $50.00 - $77.00 per problem resolution or immunizations completed. These costs (case monitoring) allocated on a per-child-screened basis would be approximately $9.00 - $12.00. These cost estimates, however, do not include any proportionate share of support for state level program infra-structure such as state and intra-state regional level program management and data processing. (Report #4).

. . To achieve "show for treatment" rates of 80-90 percent using the structured case monitoring system requires approximately one full time equivalent case monitor per 112 average constant problem workload (or one FTE [Report #3] per 750 eligible children [or 295 families] at 50 percent participation rate, and a 30 percent problem finding rate).** The case monitoring FTE per projected average constant workload is the more adaptable figure for it allows the local/state planner to respectively project specific location participation rates and problem finding rates. It should be noted that the case monitoring FTE per eligible population cited above had to be based upon an assumed participation rate, and problem finding rate. In Dallas, because of the exceedingly low problem finding rate, (10 percent), the one FTE per 112 average constant workload relates to one FTE per 2,724 eligibles (or 885 families) at a 50 percent penetration rate. (Report #3).

. . There are valid indications that approximately 52 percent of problems found in screening will reach treatment without specialized (personal) follow-up. The redistribution of current case monitoring costs to only those problems needing follow-up (the residual 48 percent) would produce extremely high costs on the basis "problem monitored to show for treatment". There are also other indications that case monitoring of all problems may not be justified. It is suggested for consideration or demonstration/evaluation, that case monitoring be prioritized to focus on health conditions that are severe and children considered unhealthy, as well as on problems still untreated 45 days following screening. (Reports #3 and 4). In no event do these recommendations preclude the requirement to fully inform the parent concerning the problem at time of screening.

. . Improvement, through follow-up, in the rate of immunizations brought current for age subsequent to screening (completion of series initiated at screening) does not appear to be effectively addressed through monitoring, per se. In a voluntary program context, short of a communicable disease emergency, a form of "in-home immunization" campaign

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*At an assumed 30 percent problem/immunization referral rate.

**750 x .50 x .30 = 112

associated with mobile immunization clinics in high risk neighborhoods may be the only effective means of achieving target area high levels of "current for age". (Reports #3 and 4).

. . There appeared to be negligible difference in success rates between case monitors assigned full time to that task and those with split responsibilities between case finding and case monitoring. (Report #3). Nevertheless, combining the functions of case finding and case monitoring into a single worker, appears to offer greater flexibility to deal with shifting workloads between the two functions and offers the advantage of a single worker dealing with the client.

. . The relative effectiveness of different skill categories of workers (Public Welfare Workers and Community Service Aides) as case monitors in a public employee role was non-conclusive. (Report #3). However, as stated in the earlier section on case findings, these workers can be more effective if culturally/ethnically identified with the main body of eligibles being served. (Report #4).

Screening

. . The accessibility and availability of screening sites has a direct impact on "kept appointments" and program participation. Neighborhood screening clinics in community contributed space (churches, fraternal meeting halls, etc.) generally within an average of eight to ten blocks of homes, have been highly successful in increasing program participation. (Reports #3 and 4).

. . High "kept appointment" rates for screening in the neighborhood clinic configuration maximized effective utilization of the screening team manpower and resulted in a cost of $19.40 for screening including the cost of voluntary screening aides at minimum wage rates. (Report #4). This cost is exclusive of any proportionate share of support for state level program infra-structure such as state intra-state regional level program management and data processing support, etc.

. . There is an urgent need within the EPSDT program for quality assurance measures and consistency in reporting. Wide variations between health activities, both between and within states, in findings of abnormalities from tests and measurements, in referrals for treatment based upon abnormal tests, and in rates of type conditions (problems) found and referred are all indicators of this requirement. Valid statistical comparisons of EPSDT programs and the relative health of children in the various states in these areas is precluded until such standards are formulated and utilized. (Report #4).*

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*Note also pages 4 and 6, Review of Shows for Treatment: EPSDT - a Nine State Survey, Health Services Research Institute, The University of Texas Health Science Center at San Antonio, March 31, 1977.

. . Screening in homes is a feasible concept. The cost per screen was approximately $48.00. Screening in homes, as a case finding mechanism, should only be utilized in special situations. (Report #4).

. . Volunteers can be effectively utilized as medical aides in screening if they are appropriately trained and if their participation is a component of a structuralized agreement so that positive coverage of tasks is generally assured. (Report #4).

Diagnosis and Treatment

. . The incremental medical costs for diagnosis and treatment for children screened in the Dallas project were estimated at $7.00 - $15.00 per child screened for the year following screening. (Report #4). (See discussion on Summary of Costs following, and paragraph 5, Chapter IV, Costs).

General

. . the mean and median number of days to complete various sub-processes of EPSDT activities in this project were as follows: (Report #4).

	Mean No. of Days	Standard Deviation	Median
Date of family contact to date of show for screen	25*	18	25
Date of show for screen to date of show for treatment	35	49	19
Date of show for treatment to date of treatment completion	72	67	50
Date of show for screen to date of treatment completion	107	73	91
Date of family contact to date of treatment completion	132	--	--

Approximately 90 percent of problems identified in screening (for referral) "showed for treatment" by the end of three months (90 days), and completed treatment by the end of six months (180 days).

*A weighted mean involving up to three appointment efforts to achieve a "kept appointment".

Summary of Costs

Case Finding

Range per child screened (show for screen) $25-$30

($35 at approximate 68 percent "kept appointment" rate; $25 at an approximate 85 percent "kept appointment" rate; both in the range of a 55-65 percent penetration (participation rate).

[In-Home Mode - Estimated $30.00]

Screening

Range per child screened $20-$25

(Ongoing program - reimbursable price - approximately $22.50; Neighborhood Clinics Sector C - $19.40).

[In-Home Mode - $48.00]

Diagnosis and Treatment*

(The incremental [add-on] costs derived from the differences in Medicaid billings for one year prior and one year subsequent to the date of screening [n = 760]).

Range per child screened $7.00 - $15.00

EPSDT, per se, in the Dallas project area had minimal impact on Medicaid diagnosis and treatment costs. The average Medicaid cost per child in the year before screening was $111 and $122 in the year following screening. What real costs occur that can be directly attributable to EPSDT are so minimal, 6-13 percent of the Medicaid total, as to be obscured by the randomly occurring far greater sick costs (87-94 percent). The real diagnosis and treatment costs per child screened are estimated to average $7-$15 per year. See discussion of Diagnosis and Treatment costs in Chapter IV.

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*Includes inpatient (all hospital) and outpatient (Medical) costs, laboratory, X-ray, pharmacy, optometric, etc. (dental and screening charges are not included).

Case Monitoring	
Range per immunization and medical problem monitored	$31 - $40
Corresponding range per child screened	$ 9 - $12
Total of costs (per child screened) at the mid-point of the ranges indicated.	$71.50 (1)(2)
If Dental Added (based on other studies)	
Dental diagnosis and treatment per child screened	$20.00
Case monitoring dental cases per child screened	8.60
Total costs added for dental per child screened	$28.60
Total of costs (Medicaid and dental) per child screened	$100.10 (3)(4)

[1]Excludes state and intra-state regional infra-structure costs and state level data processing costs which are estimated to add approximately 12 percent to the above total (total including infra-structure and DP = $80.08).

[2]In-home screening = $99.50 + $11.94 (infra-structure and DP = $111.44).

[3]Total including infra-structure and DP = ($112.11).

[4]In-home screening = $128.10 + $15.37 (infra-structure and DP) = $143.47.

SUMMARY - PART II

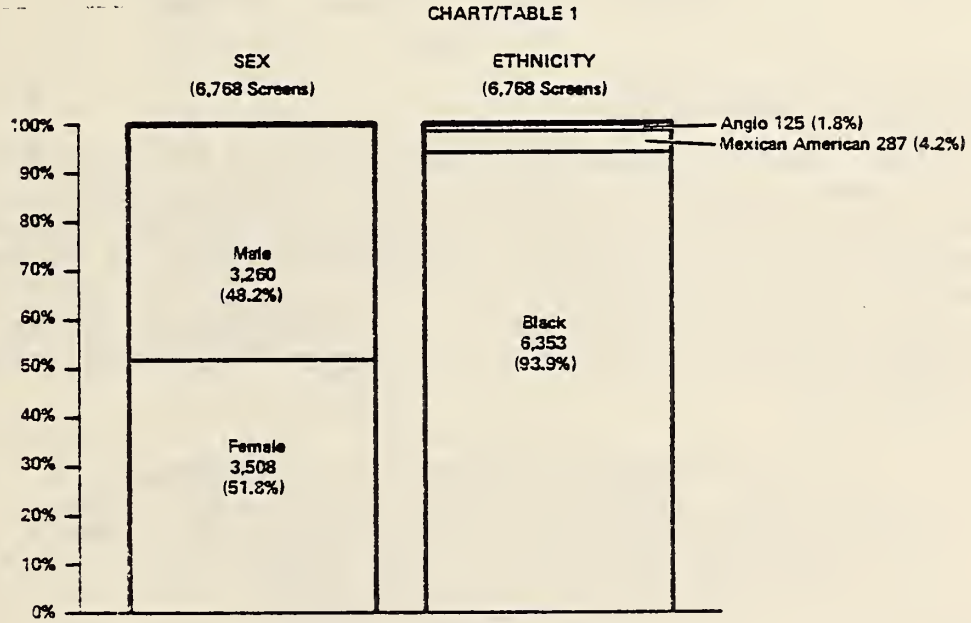
The EPSDT Population

General

The following findings present overall data pertaining to participants in the project, both in the experimental and control sectors. The data is generally aggregated over the duration of the project. The overall numbers, therefore, may not always correspond to others in the report which are usually specific to the experimental sectors.

Ethnicity and Sex- Chart/Table 1

Ninety-four percent of the children in the project were Black; 4.2 percent Mexican American, and 1.8 percent Anglo. Fifty-two percent of the children were girls, and 48 percent, boys.

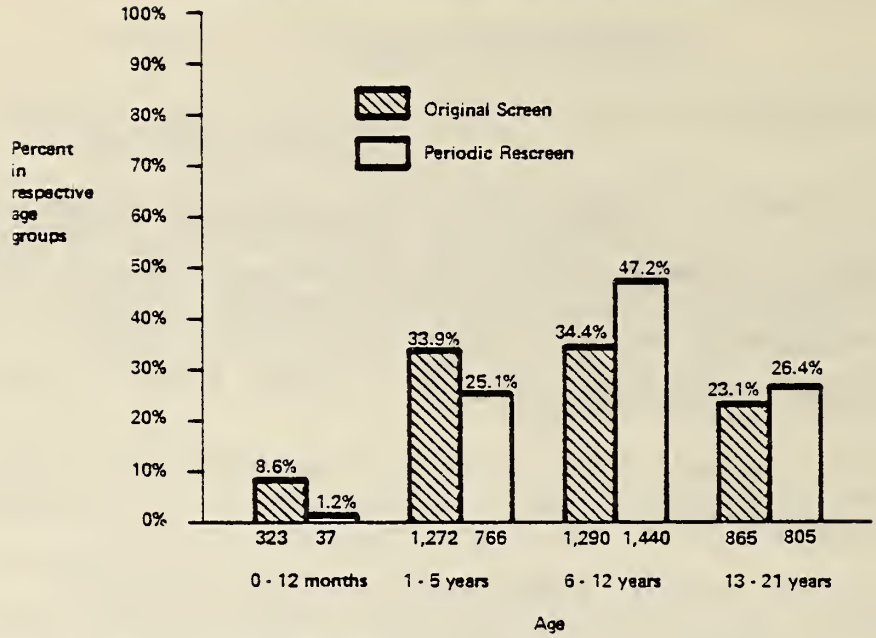


Age Distribution - Chart/Table 2

Generally 8.6 percent of the children screened (original screens) were infants under twelve months of age; 33.9 percent 13-60 months; 34.4 percent elementary school age (6-12 years); and 23.1 percent junior/senior high school and college age (13-21 years). In another categorization, 42.5 percent were pre-schoolers and 57.5 percent school or post-school children.

CHART/TABLE 2

AGE DISTRIBUTION OF PARTICIPATING CHILDREN
(In four age groupings from both Original and Periodic Screens)

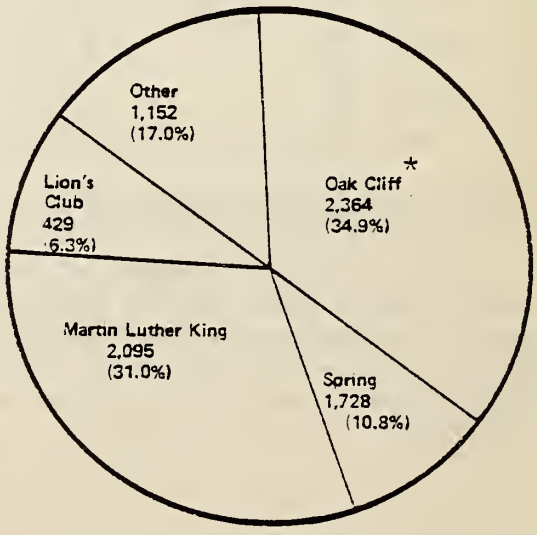


Screening Sites - Chart/Table 3

In phases 1 and 2, the project area children in Sectors A,B,C, and D were all screened at the City of Dallas EPSDT screening sites. It was only in Phases 3 and 4 that the children in Sector C were screened by the project screening team in their mobile (neighborhood) sites or "in-home". These latter sites are included in the "other" category in Table 3. As indicated, 66 percent of the screenings were accomplished at the two primary sites of Martin Luther King and A. Harris Center. These were both excellent modern facilities.

CHART/TABLE 3

SCREENING SITES AND RELATED SCREENS
(6,768 Screens)



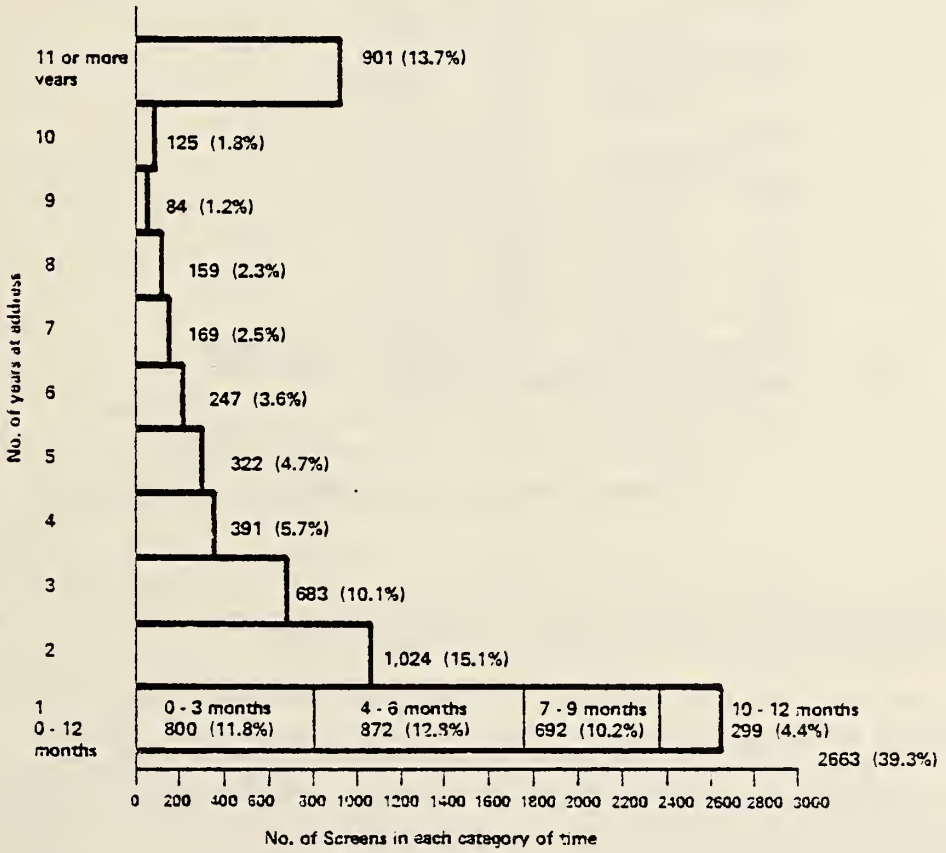
* A. Harris Center

Length of Time at Current Address - Chart/Table 4

Approximately 40 percent of the children screened had lived at their current address less than one year. Almost 12 percent had lived at their current address less than three months. This latter factor alone contributes significantly to the inability of case finders/case monitors to contact all eligibles and to trace problems to treatment even though the caseworkers were using monthly updated rosters of eligibles and addresses.

CHART/TABLE 4

LENGTH OF TIME LIVING AT CURRENT ADDRESS
(6,768 Screens)



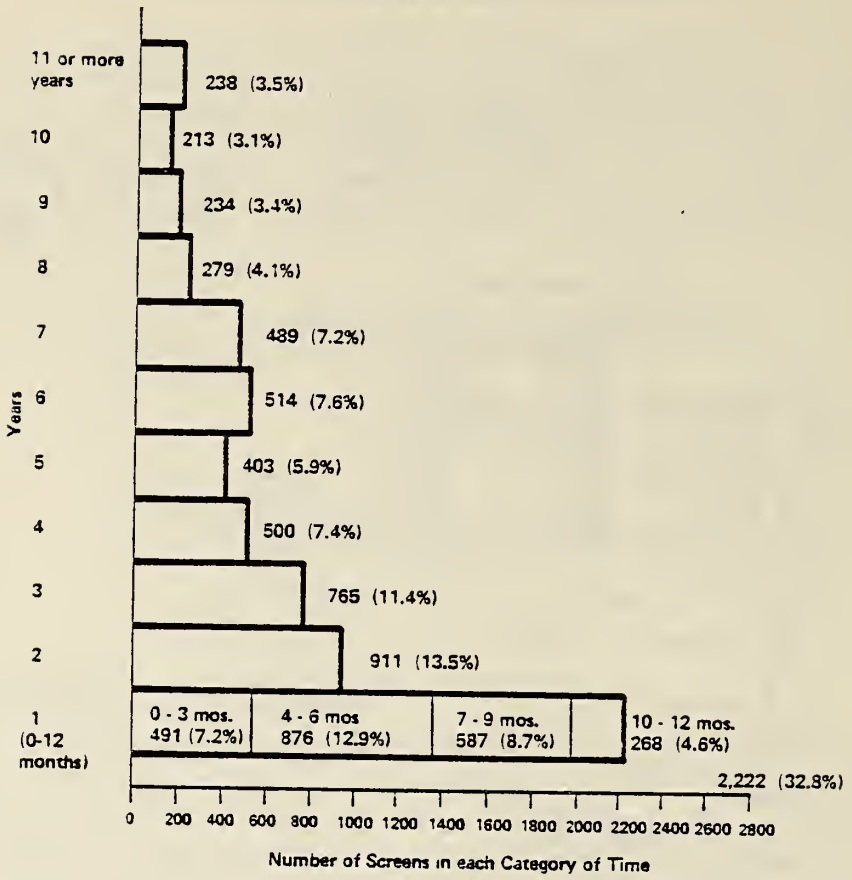
Length of Time on Medicaid - Chart/Table 5

Approximately 33 percent of the children were on Medicaid during this period of eligibility less than one year. Slightly over 20 percent had been eligible for less than six months. This, coupled with the frequency of change of address discussed above (Table 4), virtually precludes contact (participation) and treatment (of problems found in screening) goals achieving the 100 percent level indicated by the Congress*

*U.S. Congress "Department of Health, Education and Welfare's Administration of Health Programs: Shortchanging Children" September, 1976

CHART/TABLE 5

LENGTH OF TIME ON MEDICAID THIS PERIOD OF ELIGIBILITY
(6,768 Screens)



Mode of Transportation to Clinics - Chart/Table 6

The data on mode of transportation is divided between project clients and on-going program clients to avoid distortion of the results. The data relating to the on-going program is considered more representative of the average urban setting similar to Dallas in which scheduled transportation is provided to clients from home to screening sites. In cities in which public transportation is more readily available than Dallas, the number of clients utilizing public transportation may be greater.

Significantly, in both instances (project and on-going), approximately one-third of the clients utilized government provided transportation of one form or another* to get to the screening site.

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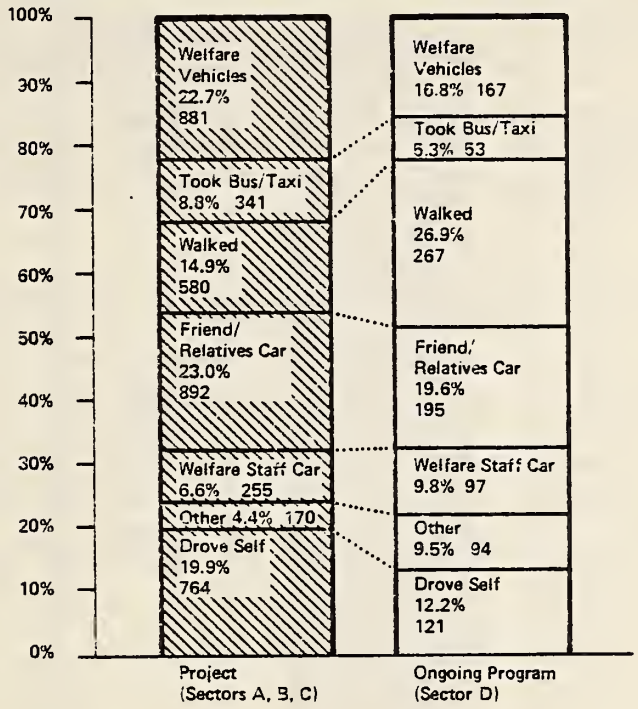
*Welfare vehicle, staff worker's car, or free bus or van.

CHART/TABLE 6

CLIENT INDICATED MODE OF TRANSPORTATION TO EPSDT SCREENING
(Project and Ongoing Program Comparison-Percent of Total Screens in Each Category of Transportation Mode - 4,877 Screening Sheets)



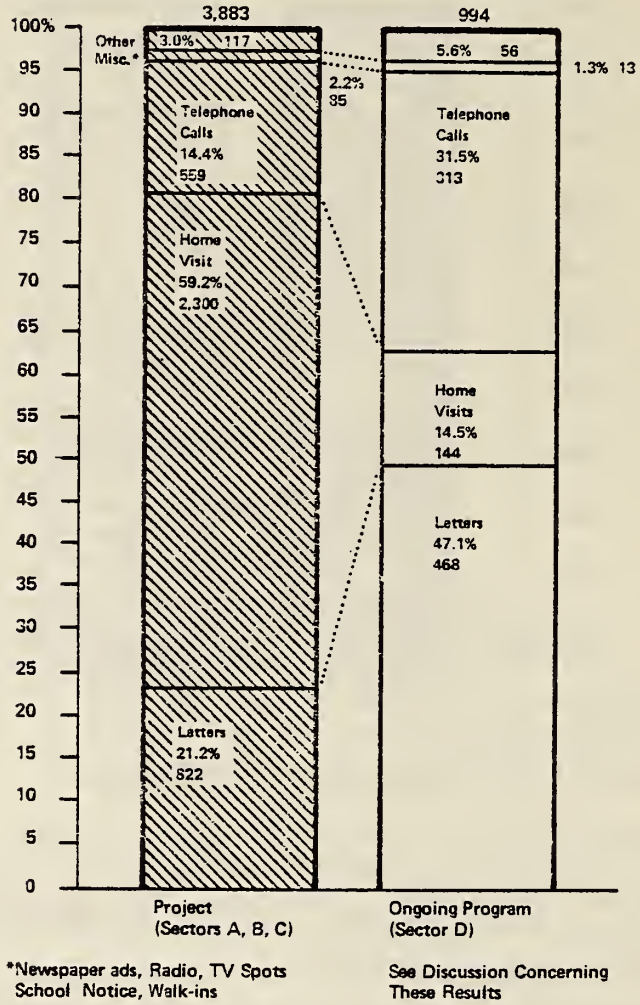
Source of Referral to EPSDT Screening - Chart/Table 7

Since the basic methods of outreach (case finding) differed so significantly between the project (home visit) and the on-going program (a sequentialed approach of letters, telephone calls and in-home contacts) these data on source of referral to screening are differentiated between the project and the on-going program.

It must be borne in mind that these data are reported by clients who do keep appointments. They do not reflect the "no shows". In this instance the data, as depicted, tend to present a more favorable response to "letters," per se, than experience in other programs or projects would substantiate. Letters, in themselves, are rarely no more productive than 10 percent "shows" of those contacted. Additionally, these data were not "probed" hence in many instances the client may be reporting the most recent contact that may have been associated with transportation arrangements or confirmation of appointment rather than the motivating source to participate in EPSDT, which was the factor being sought.

CHART/TABLE 7

CLIENT INDICATED SOURCE OF REFERRAL TO EPSDT SCREENING
(Project and Ongoing Program Comparison-Percent
of Total Screens in each Category of Referral Source
4,877 Screens)



Previous Medical Care--Acute and Preventive - Chart/Table 8

Acute/Sick Exposure

Approximately 27 percent of the children, as reported by their mothers, had one or more sick visits to either a private physician, out-patient clinic, or an emergency room during the twelve months prior to screening; 64 percent had no sick visits of any kind.

Approximately 5 percent made one or more acute visits to a dentist, and less than 1.0 percent to an ophthalmologist/optometrist.

Approximately 8 percent of the children had a hospital admission in the previous twelve months.

Preventive Health Exposures

Approximately 10 percent of the children, as reported by their mothers, had one or more preventive health visits to private physicians or outpatient clinics during the twelve months prior to screening.

Approximately 19 percent had at least one preventive dental visit (check-up), many presumably as a result of the Texas Title XIX Dental Program, and 6 percent at least one visit to an optometrist/ophthalmologist.

CHART/TABLE 8

PREVIOUS MEDICAL CARE: NUMBER OF PARENTALLY REPORTED ACUTE AND PREVENTIVE VISITS
12 MONTHS PRIOR TO SCREENING
(6,768 Screens)

	Preventive (Check-Up) Visits							Acute Sick Visits						
Types of Care	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Private Physician	6,478 95.7%	275 4.1%	5 .1%	2	2	2	1	5,290 78.2%	1,047 15.5%	182 2.7%	99 1.5%	63 .9%	26 .4%	19 .3%
Outpatient Clinic	6,314 93.3%	382 5.6%	28 .4%	12 .2%	17 .3%	5 .1%	5 .1%	6,176 91.3%	450 6.6%	52 .8%	33 .5%	25 .4%	4 .1%	28 .5%
Emergency Room	//////	//////	//////	//////	//////	//////	//////	5,731 84.7%	959 14.2%	44 .7%	19 .3%	6 .1%	2	1
Hospital Admissions	/////	/////	/////	/////	/////	/////	/////	6,229 92.0%	511 7.6%	18 .3%	6 .1%	2	–	2
Dentist	5,572 81.4%	1,234 18.2%	14 .2%	6 .1%	–	–	–	6,464 95.5%	200 3.0%	59 .9%	15 .2%	14 .2%	9 .1%	7 .1%
Optometrist/ Ophthalmologist	6,357 93.9%	404 6.0%	5 .1%	1	1	–	–	6,732 99.5%	31 .5%	1 .1%	1	–	–	–
School Physician	6,739 99.6%	29 .4%	–	–	–	–	–	6,758 99.9%	10 .1%	–	–	–	–	–
Other	6,762 99.9%	6 .1%	–	–	–	–	–	6,768 100%	–	–	–	–	–	–

Screens Completed - Chart/Table 9

The data indicates that 28.6 percent of the screens were complete and 71.4 percent incomplete. This result is largely a matter of categorization and procedure as it applies primarily to laboratory and other tests. The Dallas City Health Department would consider that close to 100 percent of the screens were complete. The problem in this situation for the evaluator is that, for example, the standard provided by the Dallas Health Department prescribes a "TB Mantoux" for all children over six months of age, without other qualifications. Nevertheless, there are many instances in which children over six months are not administered the TB Mantoux. From a data entry point of view, we have no alternative but to categorize these as incomplete, notwithstanding that abnormal results were recorded for only 1.9% of those administered (Reference Table 14). The RPR* test is another

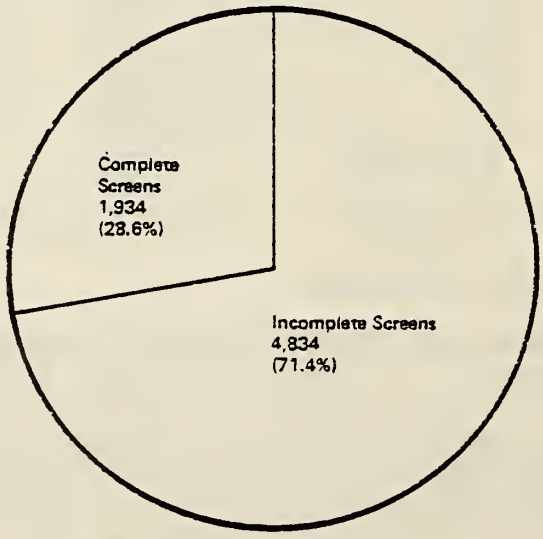
*Rapid Plasma Reagin - test for syphilis.

example where the guidelines prescribe its administration without qualification, but in a number of instances, the blood sample is hemolyzed when it reaches the State laboratories--the test cannot be performed and no result is available for recording. Again, from the data entry and analysis point of view, without a prescribed basis for programming exceptions, we have no alternative but to consider these as incomplete screens based upon omission of a test result, and in this instance, abnormal results were recorded for only 0.2% of those administered (Reference Table 14). It is because of this dichotomy that this situation exists.

In a similar vein, the Dallas Health Department's retest policy on "positive" test results is in the context of a "one shot" screen. The original HSRI data system was designed to reflect an incomplete sequence for all positive results not retested.* It has been reprogrammed in this situation to reflect an incomplete on a retest only when a retest is specifically (rather than routinely) prescribed. This "one shot"** approach is favorable for higher screen completion rates--and conceptually, is a desired objective. It usually, however, presupposes that laboratory tests are administered and evaluated (read/interpreted) at the time of screening, or a means provided the mother to read and report the results.*** In the Dallas situation, most laboratory tests are sent to the State Laboratory for analysis with results available to the screeners in the deferred sequence of 14-21 days.

CHART/TABLE 9

SCREEN COMPLETION SEQUENCES
(Screens Initiated and Completed)
(6,768 Screens)



See Discussion Concerning these Results

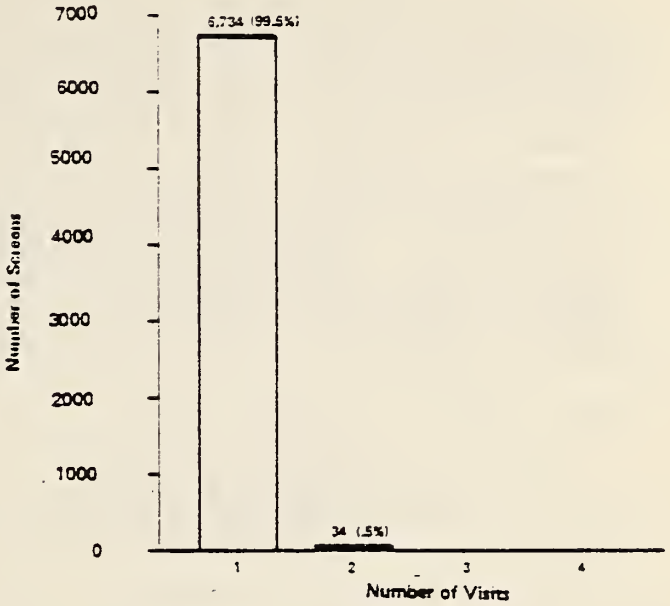
*A Guide to Screening. American Academy of Pediatrics, June 1974
**"One Shot": a screen completed in one visit.
***Such as the Lederle-Tuberculin Tine Test Record (self reader)

Number of Visits to Close Screening - Chart/Table 10

The data indicates that 99.5 percent of the screens were closed in one visit, and 100 percent in (the remaining .05) two visits. This is a reasonable result in the context of a "one-shot" screen (see discussion of Table 9 immediately preceding).

CHART/TABLE 10

NUMBER OF CLIENT VISITS REQUIRED TO CLOSE A SCREEN INCLUDING RETESTS, ETC.
(6,768 Screens)

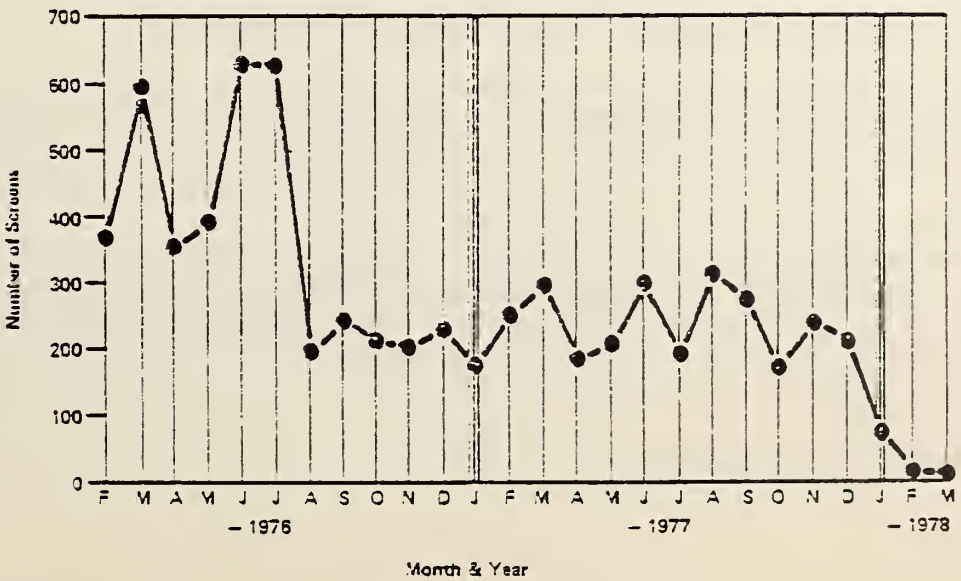


Screens by Month of Project-Chart/Table 11

The high average number of screens (486 per month) in the first six months of the project is largely a matter of categorization as "project"/ "non-project" screens. It was in this period that "on-going" workers were involved with project clients as well as project workers (student case finders). The subsequent average monthly number of screens (222 per month) reflected is more validly representative of the screens generated by the project.

CHART/TABLE 11

NUMBER OF SCREENS BY MONTH OF PROJECT
(6,765 Screens)



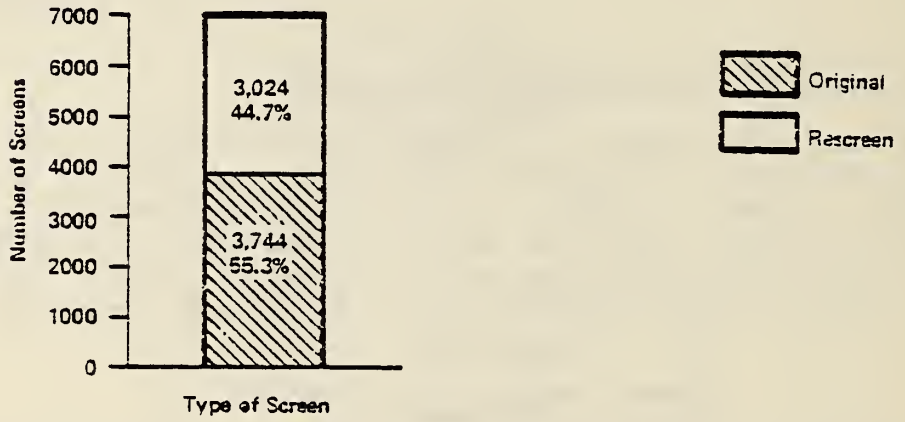
Screen Distribution: Original and Periodic Rescreens Chart/Table 12

Approximately 52 percent of the screens were original screens, and 45 percent periodic rescreens.

When an EPSDT program reaches this level of periodic rescreens, it, in itself, may often be indicative of a high level of participation by the eligible population. There were, however, indications in Phase 1 and 2 (see Phase 1 and 2 reports) that some case finders were focusing on "finding" rescreens rather than original screens on a presumption that the screening appointment "show rate" would be higher since these clients were, in a sense, already program participants. This presumption was proven to be unfounded. Rescreens require essentially the same degree of effort to recruit as original screens. This focus of effort on rescreens at one phase of the project may somewhat skew the normal distribution of case finding effort on the side of the periodic rescreens.

CHART/TABLE 12

SCREEN DISTRIBUTION:
ORIGINALS AND PERIODIC RESCREENS
(6,768 Screens)



Healthiness Ratings of Screened Children - Chart/Table 13

A "healthiness rating" of children on a scale of 1 (unwell) to 9 (well) was employed in the project. The examining nurses at the screening sites, in accordance with general guidelines provided by the HSRI*, rated each child. The healthiness rating was originally intended to be used as a gross measurement of the changing health of children (an outcome) over a period of extended exposure to EPSDT. However, as the data in the table indicates, the favorable change between the healthiness status of children as reflected in the periodic rescreens as contrasted with original screens is, in this instance, statistically inconclusive. It can be validly

*See Appendix A, this Summary.

postulated that in this project of two years of operational activity, there was insufficient contact with a continuum of preventive and acute health exposures to demonstrate improved health.

Second thoughts concerning the measurement of the health status of children indicates that in the future such measurements must be age group specific rather than in the overall, i.e., 0-12 months; 13-36 months; 37-60 months; 6-12 years; 13-21 years in order to account for the variations in occurrence of specific problems in children of different ages.

Long term studies of the impact of preventive health programs on the health of children have been proposed and are urgently needed.

The healthiness rating, notwithstanding, has a real value. It does indicate that the EPSDT program in a two-step mode is essentially a preventive health program and not an acute or chronic health care program. The fact that less than one percent of the EPSDT eligible children screened were categorized in the lower grouping (unwell) of three of the nine ratings is itself revealing as is the fact that approximately 92 percent of the children are generally categorized in the upper group of the three ratings of well. There is some distortion in these findings toward "well" over that that would be anticipated in other jurisdictions due to the separateness of the dental Title XIX program in Texas. In other terms these ratings minimize the impact of a dental assessment, which, if fully included, would certainly have an adverse type impact. Nevertheless, this general distribution of healthiness status indicators of children is compatible with that found in other short term EPSDT projects. Another value of the healthiness ratings is the ready identification it affords of children who should be "prioritized" for program surveillance (case management).

As a normal aspect of case management a special roster of the 29 cases (comprising less than one half of one percent of the total screens) comprising group "1-3" was run to determine primarily the type and number of problems associated with these children and that they were, in fact, under treatment. Each of these cases was followed up in a special study to include case documentation and interviews with the nurse screeners who assigned the original healthiness value. The study indicated that most of these children were quite severely handicapped. Fourteen were mentally retarded or had some serious emotional problems; seven had chronic musculoskeletal problems; four were severely limited in sight or hearing, and four had multiple problems.

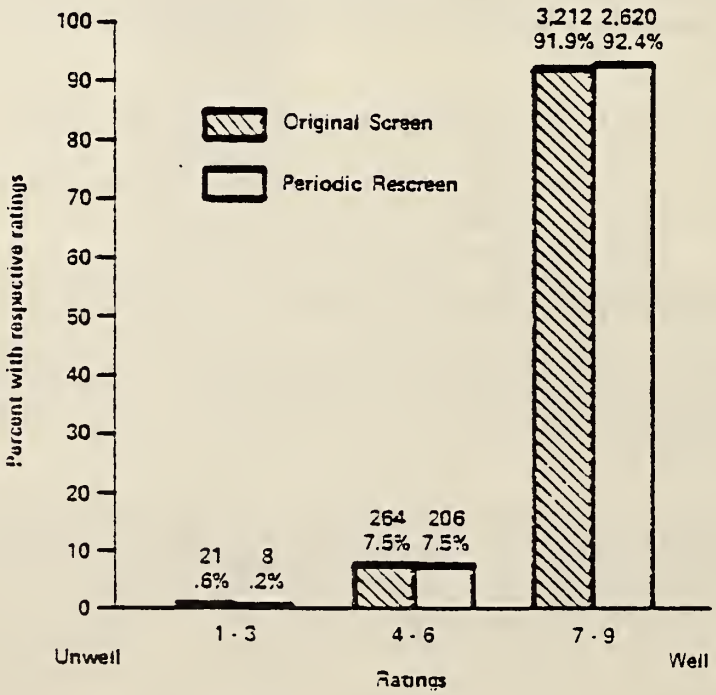
Most significant, however, was the fact that 27 of the 29 children were found to have already been under care prior to screening. Twenty-one were provided coverage by the program for the Aged, Blind and Disabled (ABD), two were in the Foster Home program and their health problems identified and covered through the provisions of that program, four were under continuing care in the private or public health sectors, and only the remaining two cases were referred for treatment as a result of the EPSDT program.

A conclusion that may be drawn from this and other EPSDT projects and exposure to a substantial number of on-going programs is that in urban areas the seriously impaired EPSDT eligibles are generally already under care through the aegis of some other categorical programs such as Crippled Children, Maternal and Infant Care, ABD, etc. Though there may be some duplication of effort between programs for these children, it is significant to note that they constitute less than one percent of the eligibles, and because of the seriousness of problems, the duplication may be a desirable "cross check."

On the other hand, there are many indications of significant numbers of children still generally outside the main stream of preventive health care. Table 8, for example, indicates that according to parental reporting, 62 percent of those children screened had had no acute health care exposure during the twelve months prior to screening, and 90 percent no preventive health care exposure. Additionally, Table 19 indicates that 41 percent of those contacted were not participating even in this high intensity program, and other data in this report (4) indicates that of the total eligibles in the entire project area, only approximately 50 percent may be participating.

CHART/TABLE 13

HEALTHINESS RATING DISTRIBUTION
(Nine Ratings in Three Groupings from both Original and Periodic Screens)
(6,331 Ratings)



These data appropriately raise the question of whether the current emphasis on avoidance of duplication of effort and overlapping through the concentration on developing interagency linkages is warranted, except for schools,* when compared to the vast number of children still outside the EPSDT program. Should not the priority of program emphasis still be on the basic issue of program participation rather than on the more refined question of duplication which affects only a small percentage of the total eligibles?

Results of Tests and Measurements - Chart/Table 14

The reporting of the results of tests and measurements in EPSDT screens in literally all project and most on-going programs raises questions concerning the incidence of abnormalities as related to the normally expected prevalence.

There is a requirement in EPSDT for the development of quality assurance measures and consistency in reporting. These could well be, for example, in the framework of broad national standards related to expected prevalence of abnormalities indicated in "A Guide to Screening" by the American Academy of Pediatrics (AAP), June, 1974. Additionally, as a component of quality assurance there is a need for some generally defined standards for identification of positive responses to components of the screen. Some effort in this direction was also indicated in the previously referenced AAP guide. Because of the uniqueness of circumstance that prevail demographically and environmentally in many sections of the country, state, and if appropriate, local guidelines (standards) paralleling the national standards should be developed.

CHART/TABLE 14

RESULTS OF TESTS AND MEASUREMENTS
(6,798 Screens)

Test	Number Given	Abnormal Results	
		Number	% of Given
TB Mantoux	351	16	1.9%
Vision	6,631	412	6.2%
Hearing	6,565	72	1.1%
Developmental	6,487	15	.2%
Urinalysis	5,339	51	1.0%
Hemoglobin	6,563	129	2.0%
Hemoglobinopathies	6,624	762	11.5%
Lead	2,280	219	9.6%
PKU	351	1	.3%
RPR	5,709	14	.2%

*The issue of screening in schools for children 6-18 is considered to be independent of this since school affiliated/associated EPSDT has long been considered potentially the most highly cost effective means of screening the age 6-18 children, but lacks effective example in a voluntary mode,(wherein participation is not legally mandated as a prerequisite to school admission).

Most of the rates of abnormal findings in Table 14 are consistent with national level expectations. Developmental finding, however, are uniquely low. Hearing results also appear to be quite low. Furthermore, as indicated in Table 15, the overall rate of problem identification, including the physical examination, is less than half of the state rate generally, and less than half the national rate.

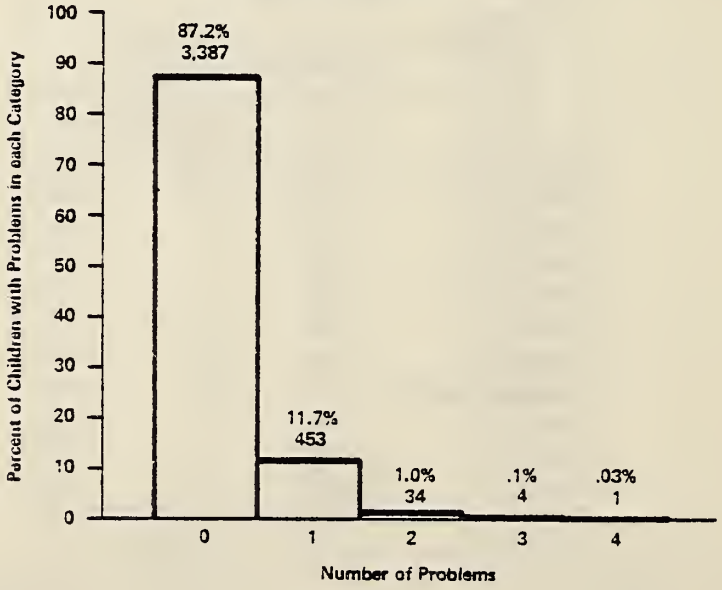
Number of Problems Identified Per Child Screened and Referred - Chart/Table15

Only 12.8 percent of the children screened in this project had problems identified for referral and treatment. There were two screening teams involved. The Dallas City Health Department team, which did 89.5 percent of the screens, had a problem finding rate of 11.0 in the children screened, and the Project screening team, which did 10.5 percent of the screens, had a problem finding rate of 21.5 percent as indicated in the discussion concerning Table 14. The overall state referral rate from children screened is approximately 25 percent. These same dichotomies exist within many states, and between states. Without adequate definition and standards, comparison, in itself, becomes meaningless.

NOTE: THESE FIGURES DO NOT INCLUDE DENTAL PROBLEMS. AS PREVIOUSLY STATED, DENTAL IS A SEPARATE PROGRAM IN THIS STATE.

CHART/TABLE 15

NUMBER OF PROBLEMS IDENTIFIED AND REFERRED PER CHILD SCREENED
(3,884 Project Screens - Sectors A, B, and C;
497 Problems Identified)
(Excludes Dental Problems)



Time Interval Between Family (Child) Contact, Show for Screening, Show for Treatment and Treatment Completion - Chart/Table 16

The mean number of days to complete various sub-processes of EPSDT activities in this project was as follows:

	Mean No. of Days	Standard Deviation	Median
Date of family contact to date of show for screen	25*	18	25
Date of show for screen to date of show for treatment	35	49	19
Date of show for treatment to date of treatment compl.	72	67	50
Date of show for screen to date of treatment compl.	107	73	91
Date of family contact to date of treatment compl.	132	-	-

Approximately 90 percent of problems identified in screening (for referral) "showed for treatment" by the end of three months (90 days), and completed treatment by the end of six months. (180 days)

There is a factor at work in these data that may have slightly extended the treatment completion sequence. As indicated in Chapter 5, the overall case management system does not provide a listing of incompleted problems (not yet resolved) for case monitor explanation until 180 days following the problem identification. The 180 days factor was predicated upon information available three or four years ago which indicated that a significant number of problems found in EPSDT would require three to six months to treat. In order then, to avoid harassment of the case monitors, it was decided to defer the final notification of incompleted problems until the end of six months. In some instances this factor in itself may have caused a lack of early aggressive follow-up by case monitors. In other words, the case closures may have been achieved earlier than indicated if there was not a tendency in some instances

CHART/TABLE 16

TIME INTERVAL BETWEEN FAMILY (CHILD) CONTACT, SHOW FOR SCREENING, SHOW FOR TREATMENT, AND TREATMENT COMPLETION
(2,253 Family Contacts;
300 Problems Completing Treatment)
(Cumulative Percent Frequency)

	Mean No. of Days	Time in 30 Day Increments						
		0 - 30	31 - 60	61 - 90	91 - 120	121-150	151-180	181+
1. Contact to Screen[1] [4]	25	//////	//////	//////	//////	//////	//////	//////
2. Screen to Treatment[2]	35	64.7%	81.4%	89.1%	94.1%	95.8%	97.5%	100%
3. Treatment to Treatment Completion[3]	72	34.7%	56.7%	66.7%	77.0%	84.7%	91.4%	100%
4. Screen to Treatment Completion	107	13.3%	35.3%	48.3%	64.3%	76.6%	83.3%	100%
5. Contact to Treatment Completion	132	//////	//////	//////	//////	//////	//////	//////

1) To show for screen at one of three attempts to achieve a successful appointment
2) To show for treatment at one of three attempts to achieve a successful appointment
3) From first show for treatment until case closure
4) Mean from contact to 1st Kept Appointment is 12 days
Mean from contact to 2nd Kept Appointment is 47 days
Mean from contact to 3rd Kept Appointment is 64 days
The overall weighted mean for the numbers keeping each category of appointments, 34%, 14%, and 3% respectively is 25 days.

*A weighted mean involving up to three appointment efforts to achieve a "kept appointment".

to "wait for the reminder". Since 91 percent of the problems were completed within the 180 days, however, this factor is not of great magnitude, but awareness of it is appropriate. As a result of this experience, the overall system will be modified in the future to provide a new "reminder" roster to case monitors at 90 days and the usual "for explanation" roster at the end of 180 days.

Problems Found and Referred by Major Diagnostic Category - Chart/Table 17

As is readily apparent from a comparison of Tables 14 and 17, many abnormal test results do not warrant referral for treatment for various reasons or are not considered severe enough to warrant treatment. Though the screening sheets indicate 412 abnormal vision test results, only 189 were referred for treatment. The discrepancy between those with abnormal vision and those referred is often due to the number of children who reportedly already wear glasses, but do not bring them to screening. Similarly, there were apparently 890 blood test abnormalities (Hemoglobin 128/ Hemoglobinopathies 762) but only in the range of 58-66 problems referred in these categories. Hemoglobinopathy's abnormalities are often sickle cell trait findings not considered referrable. There were apparently 219 abnormal lead test results, but only seven referred for treatment. These various discrepancies are also often due to the precise guidelines used by the screeners which dictate a specific severity of conditions for referral.

It is also of interest to note that there were reported 15 abnormal developmental test results and 15 referrals in the broader category of Mental Disorders (including developmental).

It might well be asked, from a review of these results, if the standards of many of the tests are not overly stringent? Additionally, as earlier stated, can comparisons in these areas (Test Results/Conditions Found, etc.) between programs in the various states, (or within some states) have any real validity without uniform criteria?

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*Note also pgs. 4 and 6, Review of Shows for Treatment - EPSDT - A Nine State Survey, Health Services Research Institute, University of Texas Health Science Center, San Antonio, March 31, 1977.

CHART/TABLE 17

PROBLEMS FOUND AND REFERRED BY MAJOR DIAGNOSTIC CATEGORIES
(663 Problem Sheets)

Type of Problem	ICDA Code Grouping	Number of Problems in Each Category	Percent of All Problems
Infective and Parasitic Diseases	000-136	7	1.1%
Neoplasms	140-239	14	2.1%
Endocrine, Nutritional, Metabolic Problems	240-279	21	3.2%
(Under/Over Height/Weight)		(13)*	(2.0%)*
Problems of Blood & Blood Forming Organs	280-289	58	8.7%
Mental Disorders	290-315	15	2.3%
Nervous System	320-359		
Eyes	360-378	42	6.3%
Vision	370 & 379	189	28.5%
Ears	380-387	44	6.7%
Hearing	388-389	9	1.4%
Circulatory System	390-458	42	6.3%
(Heart Murmurs)		(37)	(5.6%)
Respiratory System	460-519	19	2.9%
Digestive System	520-577	11	1.7%
(Hernias)		(8)	(1.2%)
(Dental)		(1)	(0.2%)
Genitourinary System	580-629	40	6.0%
(Vaginal Discharge)		(12)	(1.8%)
(Circumcision/Phimosis)		(12)	(1.8%)
Skin	680-709	47	7.1%
Musculoskeletal System	710-738	54	8.1%
(Scoliosis)		(15)	(2.3%)
(Tibial Torsion)		(16)	(2.4%)
Congenital Problems	740-759	5	0.8%
Symptons & Ill-Defined Conditions	780-796	38	5.7%
(Enuresis)		(10)	(1.5%)
Accidents/Poisonings	800-999	8	1.2%
Blood Lead		(7)	(1.1%)
		663	100.0%

*Figures in brackets ( ) represent a sub-component of the total of the broader category.

Problems Found and Referred by Age Group and Diagnostic Categories - Chart/Tables 17A and 17B

Table 15 indicates an overall problem referral rate from screens of approximately 13 percent. (Excludes dental).

In the overall, Table 19 indicates no significant difference in problems found between original and periodic rescreens. This lack of difference may be more a factor of the narrow time frame of the project rather than realistically reflecting the long range impact of EPSDT. Other studies of EPSDT with a somewhat longer perspective indicate that rescreens should reflect an improved status of health as measured by a decreasing rate of problems found.*

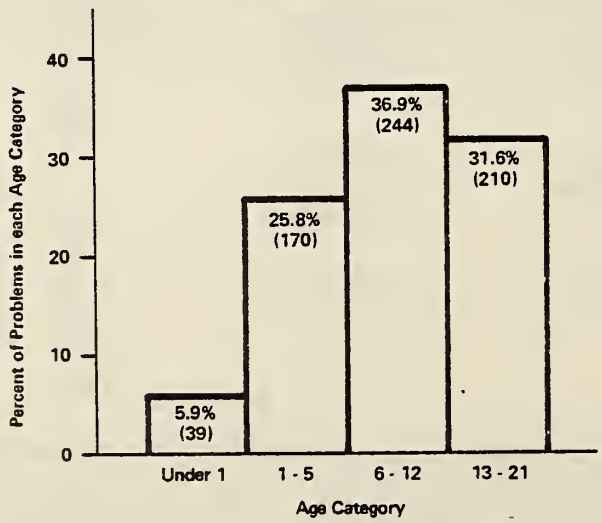
The age distribution of screens from Table 2 compared to the age distribution of problems from Table 17 indicates as follows:

Age Group	Percent of Distribution Of Screens	Of Problems
Under 1	8.6%	5.9%
1-5	33.9	25.8
6-12	34.4	36.9
13-21	23.1	31.9

These data indicated that children under six have less problems than those over six without significant delineation between the under one and one to five age groups. Table 17B indicates in the areas that numbers are highly significant that the categories of eyes/vision and ears/hearing may be most responsible for the increase percentage of problems in children over six.

CHART/TABLE 17A

DISTRIBUTION OF PROBLEMS FOUND AND REFERRED BY AGE CATEGORIES (663 Problems)



*Is EPSDT Worthwhile?" Richard Currier, MA, Public Health Reports, Volume 92, No. 6 (Nov.-Dec.'77)

CHART/TABLE 17B

PROBLEMS FOUND AND REFERRED BY PROBLEM CATEGORY AND AGE GROUP
(663 Problems)

Problem Category	Under 1		1 - 5		6 - 12		13 - 21		Total	
	Number	Percent*	Number	Percent*	Number	Percent*	Number	Percent*	Number	Percent**
1. Blood Disease	11	(19.0%)	22	(37.9%)	10	(17.2%)	15	(25.9%)	58	(8.7%)
2. Mental Disorder	0	(0%)	3	(23.1%)	3	(23.1%)	7	(53.8%)	13	(2.0%)
3. Eyes	2	(4.8%)	8	(19.0%)	22	(52.4%)	10	(23.8%)	42	(6.3%)
4. Vision	2	(1.1%)	7	(3.7%)	92	(48.7%)	88	(46.6%)	189	(28.5%)
5. Ears	1	(2.3%)	13	(29.5%)	21	(47.7%)	9	(20.5%)	44	(6.6%)
6. Hearing	0	(0%)	1	(11.1%)	4	(44.4%)	4	(44.4%)	9	(1.4%)
7. Respiratory	1	(6.3%)	5	(31.3%)	7	(43.8%)	3	(8.8%)	16	(2.4%)
8. Skin	4	(8.7%)	19	(41.3%)	11	(23.9%)	12	(26.1%)	46	(6.9%)
9. Other	18	(7.3%)	91	(37.1%)	74	(30.2%)	62	(25.3%)	245	(36.9%)
Total	39	(5.9%)	170	(25.6%)	244	(36.9%)	210	(31.6%)	663	(100.0%)

* Row Percent
**Column Percent

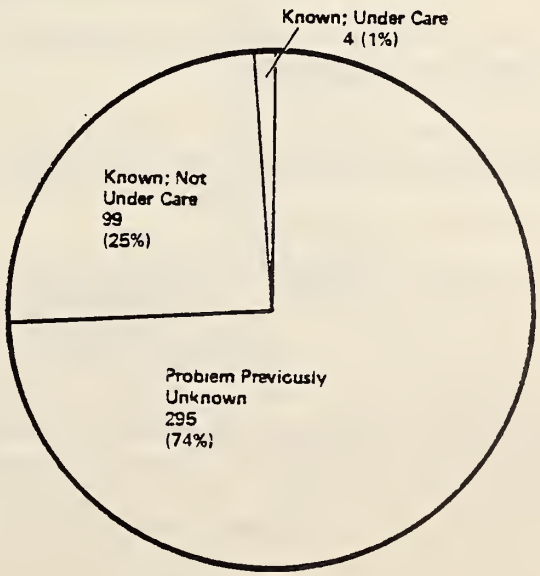
Problem History - Chart/Table 18

Seventy-four (74) percent of problems identified in screening were previously unknown to the parent, 25 percent were known but not under care, and 1 percent were known and under care.

This type finding is consistent with other data in this report such as the healthiness ratings of screened children (Table 13) which indicates that in the main, problems found in screening are minor (in their early stages) and frequently non-symptomatic to the parent. This too is consistent with appropriate expectations from a preventive health program as contrasted with a program focused on acute episodic care. It is not unexpected to find parents unaware or unconcerned about vision, hearing or nutritional problems, for example, that are only marginally abnormal. The identification of such problems and their introduction to early treatment, however, is one of the main objectives of a child preventive health program such as EPSDT.

CHART/TABLE 18

PROBLEM HISTORY
ON 398 PROBLEM SHEETS



Parental Knowledge of Problem
Prior to Screening

A "Track" Through the EPSDT System of 2028 Family Contacts, Feb. 1976-Dec. 1977. Total Contacts - Chart/Table 19; Original Contacts - Chart/Table 19A; Periodic Recontacts - Chart/Table 19B

Tables 19, 19A, and 19B are schemata representing the tracking of all family contacts (project cases - Sectors A,B, and C) made by the project from Feb. 1976 through Dec. 1977 from points of family contact to intermittent points of resolution or termination, as appropriate, through to ultimate treatment completion or other administrative termination.

A summarization of selected primary program effectiveness indicators contained in these tables follows. These indicators are considered to be quite reflective of the general status of the project's supportive program in screening, diagnosis, and treatment. These data are the overall finding of the project without regard to individual test efforts within and between sectors. Sector analysis of components being tested are addressed elsewhere in this report (Chapters II, III, and IV) and in the reports of Phase 1, 2, and 3.

Table of Primary Program Effectiveness Indicators Derived From an Analysis of 2028 Family Contacts (Representing 5317 Children) February 1976-December 1977.

	Overall	Original Screens	Periodic Rescreens
1. Of families contacted - agreed to participate in the program	89%	88%	93%
2. Of children of families willing to participate accepted screening appoint.	99.8%	99.8%	99.6%
3. Of children appointed for screening showed for screening*	65%	62%	71%
4. Of children screened - had medical prob.	13%	13%	13%
5. Of problems identified in screening-showed for treatment	68%** (72%)	66%	70%
6. Of problems showing for treatment - confirmed at diagnosis and treatment	83%	83%	82%
7. Of problems confirmed - successfully resolved	80%	80%	79%
Administratively terminated	9%	8%	11%
Still pending	10%	12%	8%
Undetermined	1%	-	2%

*To a total of three appointment attempts.

**Adjusted to include the current proportional distribution of the "as yet undetermined" would be 72%. Of the 2028 family contacts for the 23 month period of Feb.'76 to Dec.'77, 69% were for original screenings and 31% for periodic rescreens.

There are no particularly outstanding differences in results between original and periodic screens.

In the overall, the "show for screening" (kept appointments) rate (65%) is good, though it is the result of three efforts to achieve a successful appointment.

The low rate of "problems found at screening" for referral (13%) has characterized the Dallas Project throughout and has been commented upon in each of the previous reports. This rate is less than half the overall state EPSDT problem referral rate of 28.4 percent. The previous discussions relating to Tables 14 and 17 bear on the matter, though are doubtlessly not the sole explanation. Earlier comment on this matter from representatives of the State Department of Health was that the Dallas children were probably unusually healthy. It might be further speculated that some minor on-site treatment is provided, but unreported. This point, however, has never been officially confirmed.

The "show for treatment" rate of an adjusted 72 percent is somewhat disappointing on the surface, but, if viewed in light of the findings of the Nine State Survey, may be quite good for a public sector screen/private sector referral model (Two-step). The State of Texas in the overall scored 74 percent in that study on "shows for treatment" and Michigan, another state in the same mode and generally considered as having the more mature EPSDT program, scored 78 percent. It was only those states in the mode of private sector screening and treatment (Pennsylvania, Ohio) (One-step model) or a combination of both these models (California) that scored higher. It might be speculated that the maximum "show for treatment" rate for problems found in screening for states in the same mode as Texas and Michigan is approximately 80 percent.

The distribution by cause of those 140 problems not showing for treatment is as follows:

Refused to make appointment	26%
Repeated appointment failures	12%
No longer eligible	21%
Unable to contact	31%
Family moved	3%
Other	6%
Unknown	1%
	100%

Extended eligibility to complete treatment of problems found in screening, which is contemplated in new legislation for the program (the CHAP legislation) should virtually eliminate the category "no longer eligible" and expand the potential for improved rates of "shows for treatment." The other causes indicated for "no show for treatment" do not seem to lend themselves to significant adjustment for reasons stated in the discussion of Tables 4,5,13, and 18.

TABLE 19
A "TRACK" THROUGH THE EPSDT PROGRAM OF 2028 FAMILY CONTACTS
MADE IN February 1976-December 1977
DALLAS PROJECT
(Sectors A,B, & C -Project Data)
Total-Original and Periodic Rescreens
2028 Family Contacts representing 5317 children

1814 families agree to participate in EPSDT (89%)
(4836children -91%)

214 families (non-participants)(11%)
(481 children - 9 %)

Reasons for non-participation — Families

Refused to particip.	(59)	(27%)
Screened other prog.	(36)	(17%)
Other	(119)	(56%)
	(214)	(100%)

Appointed for screening: 4825 children (99.8%)

Not appointed for screening: 11 children (0.2%)

Family Contact System

Case Finding Subsystem

Showed for screen: 3134 children (65% of appointed) (59% of contacted)

Unknown: 175children (4%)

"No Show" for screening: 1516 children (31% of appointed)

No. of appointments to show

1st Appmt	(2207)	(70%)
2nd Apomt	(678)	(22 %)
3rd Appmt	(249)	(8 %)
	(3134)	(100%)

Reasons for "No show"

Family moved	(95)	6%
Family no longer eligible	(202)	13%
Refuse to make other aopmt.	(63)	4%
Unable to contact after numerous efforts	(275)	18%
Repeated apomt. failures	(462)	31%
Other	(429)	28%
	(1516)	100%

Screens initiated * 3884

Undetermined shows

Screens completed: 687 (18%)

Screens Incomplete: 3197 (82%)

Screening Subsystem

Negative findings (No problems for referral): 3387 (87%)

Positive findings (Problems identified and referred): 497 (13%)

547 problems in 497children)

Reasons for incompletion

Lab or other tests not administered or results not available	(3194
Appointment Failures	3
	3197

Case Monitoring Follow-up Subsystem

Problem resolution (533)**

Diagnosis and Treatment Subsystem

Show for treatment: 360 (68%)

As yet undetermined: 33 (6%)

"No show" for treatment: 140 (26%)

Reasons for "No show"

Refuses to make appoint.	36	26%
Repeated appmt. failure	17	12%
No longer eligible	29	21%
Unaole to contact	44	31%
Family moved	4	3%
Otner	8	6%
Unknown	2	1%
	140	100%

Problems confirmed: 297 83%

False positives: 63 17%

Resolution

Cured or inactive	Max.benefit achieved	Still under trmt.	Unable to complete
210 (71%)	27 (9%)	31 (10%)	27 (9%)!

Undetermined: 2 (1%)

Reasons for inability to complete

No longer eligible	5	19%
Refuses to make apomt.	9	33%
Unable to contact	5	19%
Repeated apomt. failures	7	26%
Otner	1	3%
	27	100%

*The difference in numbers is due to a time and process lag between contacts and screens, and the fact that these two sub-system (case-finding & screening) are not each specifically linked in the data system.

** Numbers do not match because of discrepancies in casemonitoring problems in which 14 non-project cases became involved.

TABLE 19A
A "TRACK" THROUGH THE EPSDT PROGRAM OF 1405FAMILY CONTACTS
MADE IN February 1976-December 1977
DALLAS PROJECT

(Sectors A,B,C - Project Data)
ORIGINAL SCREENS ONLY

1405 Family Contacts representing 3508 children

1236 families agree to participate in EPSDT (88%)
(3136 children - 89%)

169 families (non-participants)(12%)
(372 children -11 %)

Reasons for non-participation

	Families	
Refused to particip.	(48)	(28%)
Screened other prog.	(27)	(16%)
Other	(94)	(56%)
	(169)	(100%)

Appointed for screening
3131 children (99.8%)

Not appointed for screening
5 children (0.2%)

Family Contact System

Case Finding Subsystem

Showed for screen
1931 children (62% of appointed) (55% of contacted)

Unknown
117 children (4%)

"No Show" for screening
1083 children (34% of appointed)

No. of appointments to show

1st Appmt	(1363)	(71 %)
2nd Appmt	(410)	(21 %)
3rd Appmt	(158)	(8 %)
	(1931)	(100%)

Reasons for "No show"

Family moved	(73)	(7%)
Family no longer eligible	(143)	(13%)
Refuse to make other appmt.	(40)	(4%)
Unable to contact after numerous efforts	(203)	(19%)
Repeated appmt. failures	(338)	(31%)
Other	(296)	(26%)
	(1083)	(100%)

Screens initiated *
2176

Undetermined shows

Screens completed
378 (17%)

Screens Incomplete
1798 (83%)

Screening Subsystem

2176

Negative findings (No problems for referral)
1895 (87%)

Positive findings (Problems identified and referred)
281 (13%)
(313 problems in 281 children)

Reasons for incompletion

Lab or other tests not administered or results not available	1797
Appointment failure	1
	1798

Case Monitoring / Follow-up Subsystem

Problem resolution
(299)**

Diagnosis and Treatment Subsystem

Show for treatment
197 (66%)

As yet undetermined
22 (7%)

"No show" for treatment
80 (27%)

Reasons for "No show"

Refuses to make appmt.	20	25%
Repeated appmt. failure	9	11%
No longer eligible	15	19%
Unable to contact	27	34%
Family moved	4	5%
Other	3	4%
Unknown	2	2%
	80	100%

Problems confirmed
164 (83%)

False positives
33 (17%)

Resolution

Cured or inactive	Max. benefit achieved	Still under trmt.	Unable to complete
119 (73%)	12 (7%)	20 (12%)	13 (8%)

Reasons for inability to complete

No longer eligible	3	23%
Refuses to make appmt.	6	46%
Repeated appmt. failure	3	23%
Other	1	8%
	13	100%

*The difference in numbers is due to a time and process lag between contacts and screens, and the fact that these two sub-systems are not case specifically linked in the data system.

**Numbers do not match because of discrepancies in case-monitoring problems in which 14 non-project cases became involved.

TABLE 198
A "TRACK" THROUGH THE EPSDT PROGRAM OF 623 FAMILY CONTACTS
MADE IN February 1976-December 1977
DALLAS PROJECT
Sectors A,B,C, Project Data
PERIODIC SCREENS ONLY

623 Family Contacts representing 1809 children

578 families agree to participate in EPSDT (93%)
(1700 children - 94%)

45 families (non-participants) (7%)
(109 children - 6%)

Reasons for non-participation

	Families	
Refused to particip.	(11)	24%
Screened other prog.	(9)	20%
Other	(25)	56%
	(45)	100%

Appointed for screening: 1694 children 99.6%

Not appointed for screening: 6 children 0.4%

Family Contact System

Case Finding Subsystem

Showed for screen: 1203 children (71% of appointed) (67% of contacted)

Unknown: 58 children (3%)

"No Show" for screening: 433 children (26% of appointed)

No. of appointments to show

1st Appmt	(844)	(70%)
2nd Appmt	(268)	(22%)
3rd Appmt	(91)	(8%)
	(1203)	(100%)

Reasons for "No show"

Family moved	(22)	5%
Family no longer eligible	(59)	14%
Refuse to make other appmt.	(20)	4%
Unable to contact after numerous efforts	(65)	15%
Repeated appmt. failures	(124)	29%
Other	(143)	33%
	(433)	100%

Screens initiated *: 1708

Undetermined shows

Screening Subsystem

Screens completed: 309 (18%)

Screens incomplete: 1399 (82%)

1708

Negative findings (No problems for referral): 1492 (87%)

Positive findings (Problems identified and referred): 216 (13%) (234 problems in 216 children)

Reasons for incompletion

Lab or other tests not administered or results not available	1397
Appt. failures	2
	1399

Case Monitoring/Follow-up Subsystem

Problem resolution (234)

Diagnosis and Treatment Subsystem

Show for treatment: 163 (70%)

As yet undetermined: 11 (5%)

"No show" for treatment: 60 (25%)

Reasons for "No show"

Refuses to make appmt.	16	27%
Repeated Appmt. failure	8	13%
No longer eligible	14	23%
Unable to contact	17	29%
Other	5	8%
	60	100%

Problems confirmed: 133 (82%)

False positives: 30 (18%)

Resolution

Cured or inactive: 91 (68%)

Max. benefit achieved: 15 (11%)

Still under trmt.: 11 (8%)

Unable to complete: 14 (11%)

Undetermined: 2 (2%)

Reasons for inability to complete

No longer eligible	2	14%
Refuses to make appmt.	3	21%
Unable to contact	5	36%
Repeated Appmt. failure	4	29%
	14	100%

*The difference in number is due to a time and process lag between contacts and screens, and the fact that these two subsystems are not case specifically linked in the data system.

APPENDIX A

Definitions

H E A L T H I N E S S R A T I N G

Rating	1 2	3 4	5 6	7 8	9
Category	UNHEALTHY	MODERATELY UNHEALTHY	MODERATELY HEALTHY	HEALTHY	SUPERIOR HEALTH
Definition	LIFE THREATENING PROBLEM IF UNTREATED	LIMITED IN ABILITY UNTIL SOMEWHAT DIFFICULT CORRECTION IS ACCOMPLISHED	REQUIRES SLIGHT CHANGE IN LIFE STYLE OR SIMPLE MEDICAL CONTROL OR CORRECTION	NO OBSERVABLE DISEASE OR ONLY THAT WHICH IS BRIEF AND SELF-LIMITED	NO OBSERVABLE DISEASE: EVIDENCE OF POSITIVE HEALTH HABITS: THE "PICTURE OF HEALTH"
Examples	Cyanotic heart disease Bacterial pneumonia Severe uncontrolled diabetes Severe failure to thrive	Anemias below 28 hct Severe visual or hearing loss Malnutrition Severe Obesity	Urinary tract infection Umbilical or inguinal hernia Impetigo Anemias, 23 to 33 hct Asthma Mild hearing or visual loss	Mild URI without otitis media Few dental caries Common cold	

*Consider total health

*Numerous problems will lower the rating

Chapter I

INTRODUCTION

Background

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was enacted into law as a section of Title XIX of the Social Security Act by the Social Security Amendments of 1967 (PL90-248).

Through this amendment Congress intended to require states to take aggressive steps to screen, diagnose and treat poor children with health problems. The Congress had been concerned about the variations from state to state in the rates of children treated for handicapping conditions and health problems that could ultimately lead to costly chronic illnesses and disability.

EPSDT, in the ideal sense, is intended to be a program for comprehensive preventive and health services for "poor" children (Medicaid eligible).

Nothwithstanding the intent of the program, the unique federal/state sharing of its responsibility produced significant variations in the degree and manner in which the program has been implemented by the various states. The federal agency charged with program implementation, the Health Care Financing Administration (HCFA), DHEW, as recently as April 1977 acknowledged that the overall result to date of state programs was that only 30 percent of the 12 million children currently eligible were participating in the program.

Additionally, many critics of the program have been alleging since its inception that even those children who were participating were not adequately being provided treatment for health problems found in the screening process. In a survey of the EPSDT program in eight states, for example, in 1973, only 46.1 percent new problems found in screening were found to be treated through a Medicaid claims file check.

It was in this context of major concerns with lack of client participation in the program and failure to attain high rates of treatment for children with problems found in screening that the Dallas project was proposed.

Its specific objectives were to develop innovative, effective, and cost beneficial methods of case finding (outreach) to improve client participation in the EPSDT program and case monitoring (follow-up) to achieve increased rates of treatment for problems found in the screening process. The inbeing health care delivery system in Dallas was to be utilized for screening, diagnosis and treatment to the maximum extent possible.

The Dallas project, "EPSDT in an Urban Setting--Dallas, Texas" was approved and funded by the Social and Rehabilitation Service (later designated the Health Care Financing Administration), DHEW under Section 1115 of the Social Security Act in July 1975. The grant to the Texas State Department of Public Welfare for

the project represented an investment in both state and federal (SRS) interests in improving the EPSDT program.

Case Finding Activities

The full program of case finding variables related to time and tested over the duration of the project are depicted in the facing schema (#1).

Most states had been found to rely heavily on client contact at the point of welfare application to offer advice concerning the program and then follow up with letters or flyers with welfare checks. These techniques had been found to be only minimally productive in inducing client participation in the program, generally in the order of 5 - 20 percent.

The initial major effort in case finding in the Dallas project was to test the highly personalized case finding technique of in-the-home/face-to-face contact between worker and client to offer information about the EPSDT programs to determine its impact on the participation rate.

The finding resulting from this test, as reported in the Phase 2 Evaluation Report, May 15, 1977, was that, although approximately 85 percent of clients contacted agreed to participate in the program, roughly 50 percent of them never kept a screening appointment although three appointment opportunities were attempted.* This result prevailed notwithstanding a reasonably convenient clinic location (generally within an average of two to three miles from client homes), the provision of bus type transportation, a favorable clinic facility, and interested and concerned nurse-headed screening teams. This finding, if applicable to most other major urban areas, represented an unanticipated limitation to the program's potential.

A sequential test to this, in Phase 3, was to test neighborhood screening clinics, which materially reduced distance (and time), by a factor of six, between the client's home and screening site, to determine the impact of increased accessibility and availability of health services (screening) on the program participation rate. This variable presupposed maintaining constant, to the maximum degree possible, all the circumstances surrounding the Phase I test, e.g., the same in-home/face-to-face client contact technique, same skill level of case workers, the same level of transportation availability and like circumstances of clinic surroundings and team-client interest. The results of this test was an increase in kept appointments, after three appointment efforts, from 51 percent to 74 percent. The potential participation rate of the population eligibles by this mode of case finding/screening appeared to be in the

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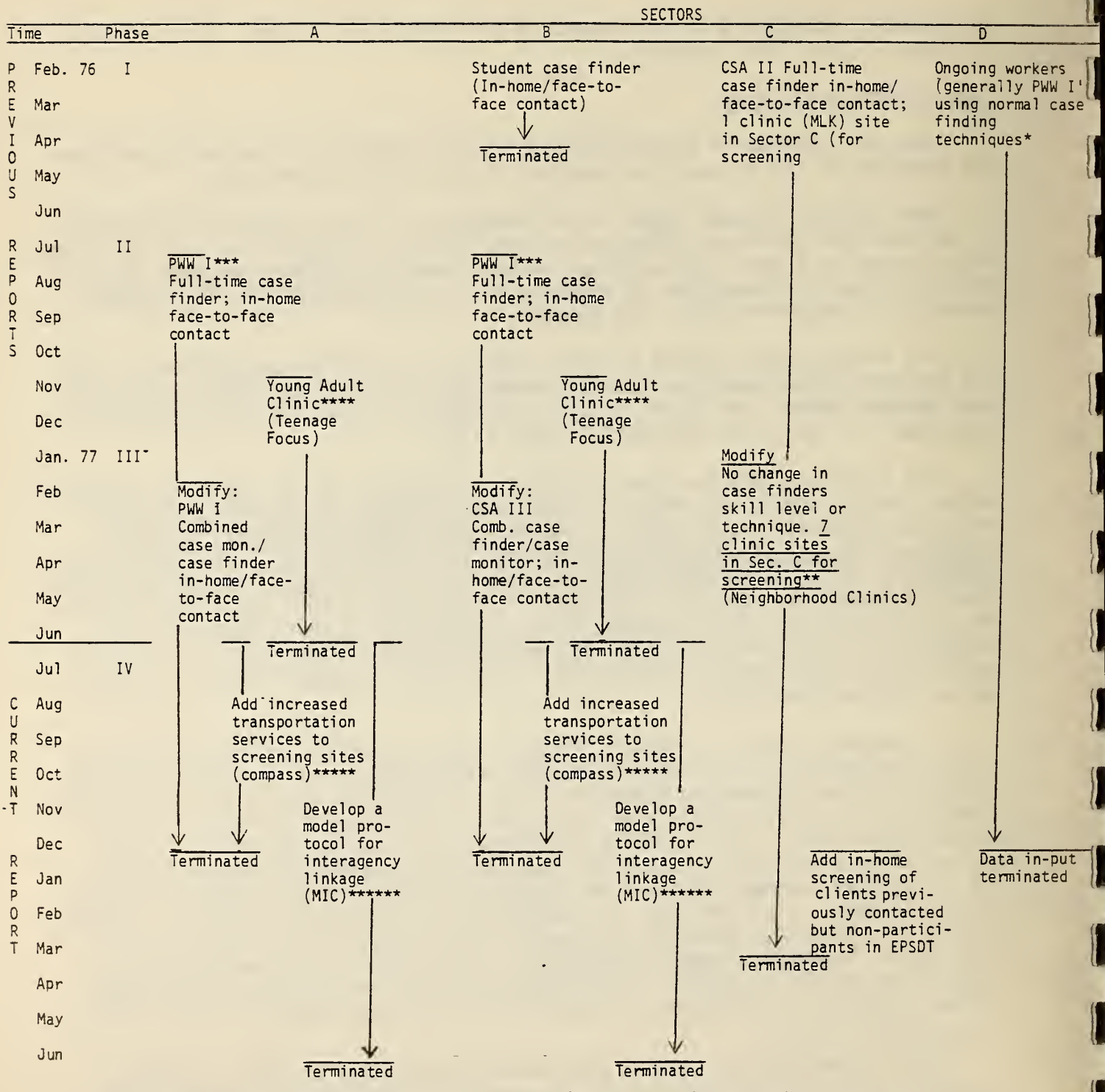
*This limitation to no more than three unsuccessful efforts to achieve a screen in the city of Dallas with its prevailing EPSDT periodicity (annually) was a project systems control to preclude further case finding effort being expended on highly doubtful outcomes. These cases were then dropped from the current year's case finding "targets" and picked up again as "new" cases in the following year. This, however, is not the practice for the State of Texas as a whole which allows its case workers to continue to recontact the repeated appointment failures as often as their judgment suggests and time allows.

SCHEMA 1

Case Finding Project Variables



*Generally PWW I's with combined case finding/case monitoring responsibilities; worker time distribution: case finding - 70%; generally allocated at 30% letter contact effort; 20% sequential telephone contact effort; 20% sequential face-to-face contact either in-the-home or with transportation assistance. The remaining 30% of time would be allocated to case-monitoring and administrative training.

**Test impact of increased accessibility and availability of health services (screening) on participation rate of eligibles (show for screen; penetration rate)

***Public Welfare Worker I

****Test impact of teenage oriented clinic on participation rate of teenage eligibles

*****Compass (Comprehensive Patient Assistance) maximize client assistance, such as personalized transportation rather than routine transportation to assess impact on kept appointments.

******MIC (Maximum Interagency Coordination) Develop a model protocol between agencies providing health services to AFDC children to minimize duplication between programs.

area of 70 percent.

In the last phase (4) of the project, efforts were made to continue testing the neighborhood screening clinics in Sector C and to test other variables that could identify the possible maximum level of participation that could be achieved in an EPSDT program in an urban setting. In this phase (entitled COMPASS-Comprehensive Patient Assistance) additional transportation was provided in Sectors A and B that, by its nature, was to be much more highly responsive to the client's needs than regularly provided scheduled/fixed route transportation. The second new variable to be employed was to test in-home screening as an extreme effort in case finding in Sector C of clients who had twice previously failed to participate in the program.

A supplementary feature of this latter variable was to determine the relative healthiness of these children as compared to the children of participating families, and, secondly, by conducting an attitudinal survey of the non-participants to determine the causes or programmatic barriers to such lack of participation.

A third new variable was to develop a model protocol of an agreement between agencies providing health services to AFDC children to minimize duplication between programs (entitled MIC-Maximum Interagency Cooperation).

It is these four case finding activities that are being reported upon in detail in this report.

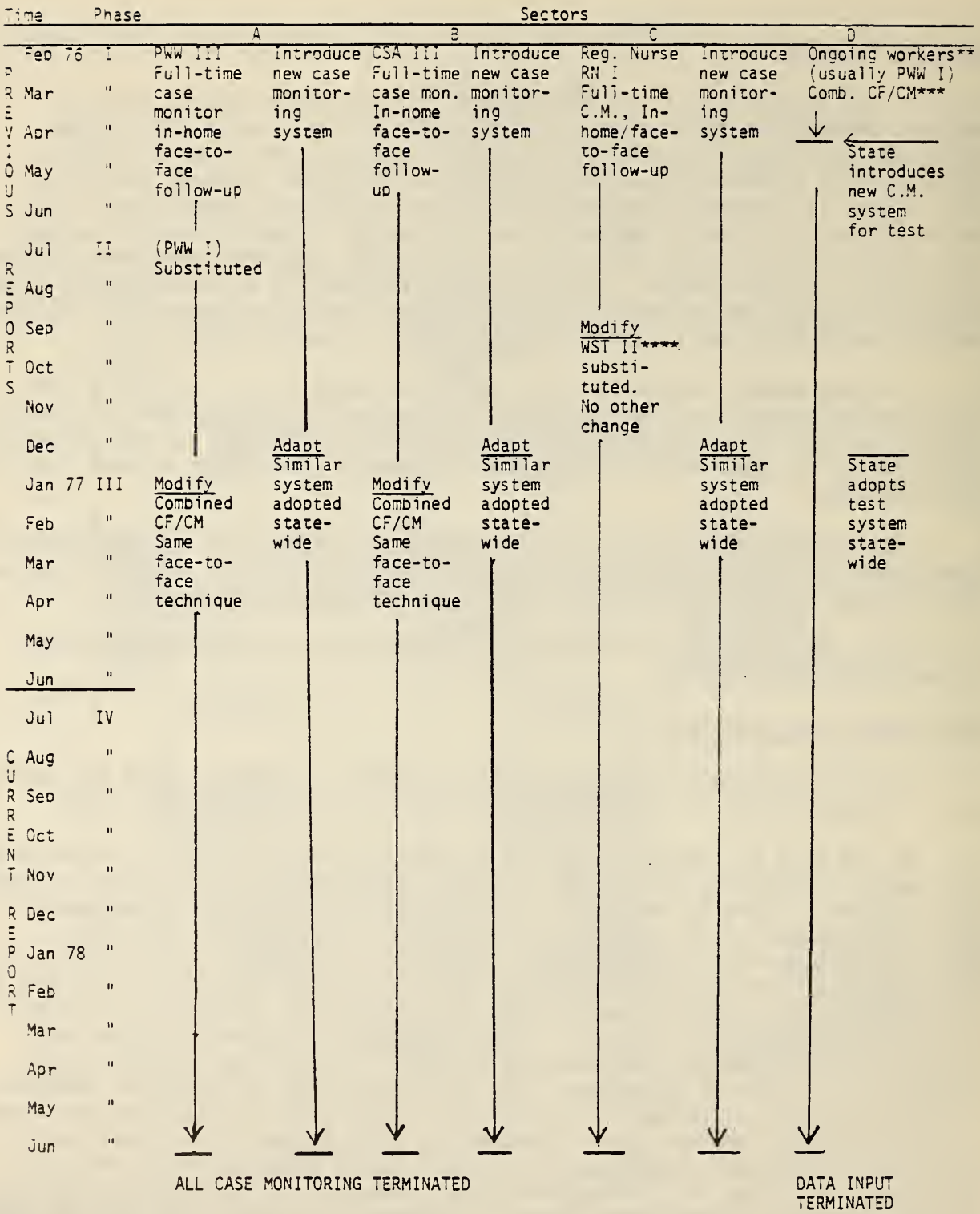
Case Monitoring Activities

The full program of case-monitoring variables related to time and tested over the duration of the project are depicted in the facing schema (#2).

At the time of the project's conceptualization, most states had not made any special provisions for follow-up (case monitoring) in their EPSDT programs. This was due in part to the fact that most states split program responsibility for EPSDT between their Departments of Welfare and Departments of Health. Responsibilities for program elements generally "fell out" fairly clearly for outreach (case finding) to the Welfare Department and screening to the Health Department, with diagnosis and treatment most often by referral to providers in the private sector of health. Since screening was generally provided through contract between the two departments, follow-up was generally not assigned to the Health Department. On the other hand, follow-up of referrals to treatment was not normally a traditional function of the Welfare Department, so was most often neglected or occasionally assigned as an additional duty to some case worker who already had many other family service responsibilities. This was the setting of circumstances that produced the attainment of treatment for 46.1 percent of conditions found in screening, earlier referenced on page 1 of this report.

The initial major efforts in this area in the Dallas project were to specifically identify case monitoring as a function of EPSDT and to institute a

Case Monitoring Project Variables*



*The case monitoring system established for Sectors A,B & C (test sectors) tracks problems found in screening to treatment and treatment completion. The control sector system (D) introduced in May only seeks to track problems to treatment--this latter tracking satisfies legal and federal programmatic requirements.

**Ongoing workers, generally PWW's, with combined case finding/case monitoring responsibilities. Worker time distribution, case monitoring - 30%; contacts with clients for follow-up are normally through letters or telephone contact and only personal contact (in-home) if the first two means of contact fail. Personal contact is minimal as compared to the test sector workers where personal contact is maximal.

***No specially designated case monitoring system in effect.

****Welfare Service Technician.

specific follow-up (case monitoring) system with full-time workers assigned to follow-up tasks (for problems and immunizations). Case monitors were, as case finders, to maximize the personal approach to clients through in-home/face-to-face contact to determine the impact on rates of treatment for problems found in screening.

The results of the introduction of a specific case monitoring system on show for treatment rates were included in report #3. The overall major finding was that the introduction of a structured case monitoring system, to include designated case monitors, referral forms, provider/client feed-back, assistance making treatment appointments and providing transportation, produced show for treatment rates in the order of 85-90 percent. The cost for such follow-up approximated $15.00-$23.00 per child screened exclusive of any state level program support for infra-structure or data processing.

There were no new variables tested in case monitoring in Phase 4, however, two new perspective to those already reported upon in previous reports are added, i.e., the prioritization of case monitoring and the appropriateness of immunization follow-up as a function of case monitoring.

Project Structure

As depicted on the cover, the project area is a sub-component of the City of Dallas made up of seven zip code areas, organized into four sectors, three of which are structured for experimental variations (Sectors A,B, and C) and one as a control (Sector D). The control is intended to represent the activities of the "ongoing" prescribed EPSDT program. An arrangement that has evolved* since the project's original submission is the presence of both "ongoing" and "project" EPSDT activities in Sectors A,B and C. In effect, 40 percent of the eligible clients living in Sectors A,B, and C are "project" (those whose Medicaid numbers end in 3,5,7 and 9) and 60 percent are "ongoing" (those whose Medicaid numbers end in 0,1,2,4,6 and 8). A detailed presentation of this distribution is as follows:

*Phase 1 and 2 Evaluation Reports for details.

Distribution of EPSDT Program Eligibles by Sector
Project and "On-Going"[1]

Sector	Zip Code Area	Total (100%)	Distribution of Eligibles Project (Approx. 40%)	On-Going (Approx. 60%)
A (A--J)	75203[2] 75208	3,583	1,378	2,205
B (K--Z)	75216 75224	3,328	1,280	2,048
C	75215	3,684	1,417	2,267
D (Control)	75210 75223	3,086	(1,187)[3]	3,086[3a]
		13,681[4,6]	4,075[5]	9,606
		(17,785)	(5,297)	(12,488)

[1]Approximately December 31, 1976

[2]Sectors A/B share the same four zip codes with delineation by alphabetical designation (first letter of last name) as indicated.

[3]Control

[3a]Includes the 1,187 used for control purposes

[4,5]This is a more or less constant total; an annual client turnover rate ('On" and "off" welfare eligibility) of 30 percent would adjust the total to 17,785[4] and the project to 5,297[5].

[6]Generally 95 percent Black; 3 percent Spanish surname; 2 percent Anglo.

Chapter II

CASE FINDING

Test Objectives - Phase IV

The major test in this report period was to explore methods to achieve the maximum level of participation in EPSDT by an urban population of eligibles.

Schema for Project Case Finding Activities (July 1977-March 1978)

The overall schema for case finding in the project throughout its duration is contained in the schema in Chapter 1, page 40. The schema on the following page portrays the case finding activities for the project for this report period only.

Program Eligibles (Target Population)

The target population (program eligibles) toward whom these case finding activities were directed was approximately as follows on December 31, 1977:

Project Area Eligible Population
(By Family, Children and Sector)

Sector	No. of Family* Clients	No. of* Children	Approximate Cumulative Annual No. of Program Eligible Children**
A	576	1356	1763
B	542	1334	1734
C	563	1415	1839
Sub-Total	1681	4105	5336
D (Control)	443	1097	1426
Total	2124	5202	6762

Designation of Variables to be Tested in this Report Period

Following is the designation of the four variables to be tested:

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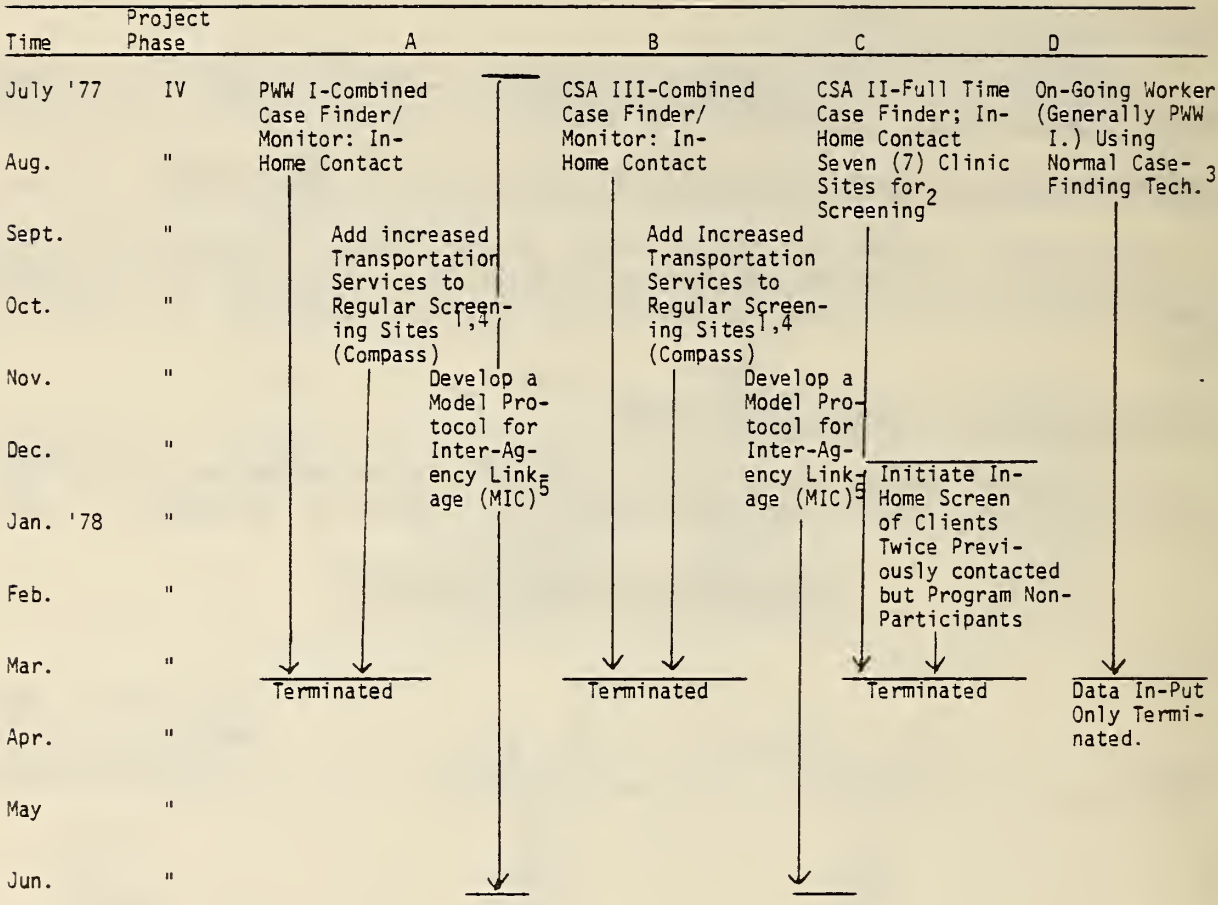
*December 1977, TDHR Eligibility Tapes

**Number of children adjusted to reflect an estimated annual 30 percent turnover rate on the DHR eligibility rolls.

Schema

Case Finding Project Activities (July '77-March '78)



[1]Usually two sites, i.e., Harris Center and Lions Club Clinic run by City of Dallas Screening teams.

[2]Continue test of impact of increased accessability and availability of health services through six additional sites run by the project screening team on participation rate of eligibles.

[3]Sequential effort of letter contact (maximum of three efforts), telephone contact of non-respondents and in-home contact of those not responding to the first two efforts in connection with generally two sites, i.e., Martin Luther King Center and Spring Clinic run by the City of Dallas Screening Team.

[4]COMPASS (Comprehensive Patient Assistance) to maximize client assistance such as personalized transportation.

[5]MIC (Maximum Interagency Coordination) to maximize interagency cooperation to minimize duplication of services to children.

(1) Neighborhood/Mobile Clinics: Continue testing of the six additional clinic sites in Sector C as a means of stimulating increased program participation (Sector C).

(2) In-Home Screening of clients who twice previously failed to participate in the program to determine the maximum level of participation reasonably achievable, and the general status of health of these children, and, as a secondary issue, ascertain through an attitudinal survey possible barriers to program participation (Sector C).

(3) COMPASS (Comprehensive Patient Assistance) The addition of more responsive transportation to the previously utilized case finding method of combined case finder/monitor, executing in-home contact as a primary technique. (Sectors A and B)

(4) MIC (Maximum Interagency Coordination) To develop a model protocol between selected agencies providing overlapping health services to children to minimize duplication of effort. This is to be a narrative description of problems and issues encountered in such an activity and the means utilized to overcome them (Sectors A,B, and C)

Evaluation of Variables

Following is the evaluation of these four variables tested in the report period.

1. Neighborhood/Mobile Clinics (Sector C)

This mode of operation was continued in Sector C from the previous test period (Phase 3) without significant modification. In brief, the primary focus of this case finding activity was to increase by a factor of six to seven the availability and accessability of screening sites to child homes to ascertain the impact on "kept appointments" for screening and rates of program participation. Seven neighborhood screening clinics were established in Sector C, where previously there had been one. The distance from homes to clinics was thereby reduced from an average of approximately 45-50 city blocks to eight to ten. All other earlier test methods of family contact and client services were held relatively constant, i.e., in-home contact by trained indigenous aides supported by responsive transportation. All facets of support and techniques were reported in detail in the Phase 3 evaluation report.

The results attained at the end of the last test period (Jan. 30, 1977) was a 74 percent kept appointment rate for screening and a projected 60-70 percent annualized participation rate.

Results of Continued Testing

(a) Family Contacts, Children Represented, and Rate of Appointments Made by Time Period--
(Sector C*)

Time Period	1 Number of Family Contact	2 No. Children Represented by Families Contacted	3 No. Families Willing to Participate in EPSDT	4 Children Represented by Families in Column 3	5 No. Apmts. Made for Children Who Will Particip.	6 Rate of Apmts. Made of Those Willing	7 Rate of Apmts. Made of Those Contacted
Phase 1 & 2 Feb. '75-** Dec. '76 (11 months)	619	1,604	529	1,387	1,365	98%	85%
Phase 3 Jan. '77-June. '77*** (6 months)	214	537	206	527	527	100%	98%
Phase 4 Jul. '77-Dec. '77*** (6 months)	226	580	222	568	566	99.7% (100%)	98%

Discussion

The 98 percent rate of appointments made of children contacted continues to reflect the high acceptability of the neighborhood clinics by the eligible population group. As earlier indicated (Phase 3 Report), apart from this statistical evidence, the case finders in Sector C reported a much more favorable reaction by the mothers to the more convenient locations of the screening sites. The neighborhood identification of the screening clinics and the closeness to home (generally not more than eight to ten blocks) has been a distinct advantage in "selling" the program. The client perceives the neighborhood clinic as a significantly reduced commitment of time to the total activity of screening, e.g., preparation time, travel time, waiting time.

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*Data derived from Family Contact File

**One Screening Site (Martin Luther King Clinic)

***Seven Screening Sites (six neighborhood clinics added)

(b) Number and Rate of Screening Appointments Made and Kept, First, Second and Third Appointments, by Time Period (Sector C*)

Time Period	1st Appointments			2nd Appointments			3rd Appointments			TOTAL - 3 Appmts.		
	No. Made	No. Kept	Rate Kept	No. Made	No. Kept	Rate Kept	No. Made	No. Kept	Rate Kept	No. Made	No. Kept	Rate Kept
Phase 1 & 2 Feb. '76-** Dec. '76 (11 months)	1,365	457	33.5%	908	197	21.7%	711	42	5.9%	1,365	696	51.0%
Phase 3 Jan. '77-*** June'77 (6 months)	527	283	54.0%	246	91	37.0%	163	17	10.0%	527	391	74.0%
Phase 4 Jul.'77-*** Dec. '77 (6 months)	566	372	65.7%	194	79	40.7%	115	23	20.0%	566	474	83.8%

Discussion

The continued and growing acceptance by the client population of the neighborhood screening clinics far exceeds the expectations of the project and evaluators. The 74 percent kept appointments at the end of the last test period was then considered to be close to the maximum level achievable with this technique. Exceedingly tenacious case finding to document a maximum (saturated) client contact of 80-90 percent of eligible families (prior to the in-home screen) and a growing identification between the mobile screening team in neighborhood sites and the client population resulted in the uniquely high 84 percent "kept appointment rate."

As indicated in the detailed evaluation of this technique in Report 3, there are factors that have come into play to somewhat affect the results other than the additional clinics, per se.

The project staff report that having all activities (outreach, transportation, screening) under a single manager (initiated July 1977) afforded a significantly more client responsive milieu than is possible under the regular program, when each is under a different director. Additionally, transportation was considerably more individualized by being under the dispatch control of the screening team chief (single manager) and mothers were more actively involved in

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*Data derived from Family Contact File

**One screening site (MLK) Martin Luther King Clinic

***Seven screening sites (Neighborhood clinics added)

the screening process with their children.

(c) Rated Program Participation (Penetration Rate), Neighborhood Clinics, Sector C* In Three Periods of Time

Time Period	In Sector C as of: Dec. 31,76	June.30,77	Dec.31,77	Who showed for screening as of: Dec.31,76	Jun.30,77	Dec.31,77	Annualized Projected Shows for Screen No	Rate**	Annualize Average Projected Case Find FTE's Avail.
Phase 1 & 2 Feb.'76-Dec.'77 (11 months)	1417			662			722	51%	2.61
Phase 3 Jan.'77-Jun.'77 (6 months)		1412			420		840	60%	1.89
Phase 4 Jul.'77-Dec.'77 (6 months)			1415			421	842	60%	1.85

Discussion

The average number of full time equivalents of case finding effort in support of the neighborhood clinics was 1.85 during the period July '77-December '77.

Turnover of clients on eligibility roles continues to restrict significant impact on further increase in penetration rate notwithstanding improved rate of kept appointments. The penetration rate only measures the "kept appointments" (show for screen) of those still eligible at the closeout of a report period. The "top" penetration rate achievable in this mode is projected at approximately 70 percent. The "top" penetration rate*** in an optimum (ideal) mode is estimated to be in the area of 70-75 percent. The discussion on page 5 of the summary is applicable to this situation and that example did not reflect the impact of turnover on welfare roles on the penetration rate. At this point it should be crystal clear that in any unduplicated count of participation of current eligibles in

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*Data derived from Texas DHR Monthly Eligibility Tapes and HSRI screening files.

**Penetration rate

***Defined as those who have "kept" a screening appointment as related to any current roster of eligibles. This definition avoids "double counting", however, there will be "kept appointments" in any reporting period for those losing program eligibility that cannot be counted toward the penetration rate.

EPSDT, 70-75 percent represents the maximum level of participation in a voluntary program.

The case finding cost "per kept appointment", in the sector was $25.12. This lower cost of case finding in this sector, compared to the average of Sectors A and B for the same time period which is $42.09, is primarily a factor of the higher sustained show for treatment rate reflecting a more effective utilization of the case finding efforts (full time equivalents and other related costs).

Conclusion

The mode of case finding/screening that may be expected to produce the highest rates of participation in an EPSDT program in a two step configuration in an urban setting at the most efficacious cost is: (Reports 2,3, and 4)

- case finding aides* indigenous to the target population area (either as contact or public sector employees)
- family contact to recruit EPSDT participation by a home visit (face-to-face contact)

Or (Equal Option)

- family contact through a series of contact efforts consisting first of a mailing of up to three letters; second, phone calls to non-respondents to the letters; and third, in-home contact of those not responding affirmatively to the first two efforts.
- screening sites (neighborhood clinics) highly accessible to the target families, generally within ten blocks of homes.
- transportation that is highly responsive to client needs, generally under dispatch control of the respective clinics.
- single management (or operational control at the local level of the outreach (case finding), transportation and screening activities relative to an EPSDT screening.
- parent participation to the maximum extent feasible in the screening process itself, and in the evaluation of the results (nurse or doctor/parent consultation).

This mode of EPSDT case finding/screening should be expected to produce program acceptance rates of 98 percent by families contacted and "kept appointment" rates for screening in the range of 80-90 percent at a case finding cost of $25-$30 per child screened (including transportation costs) and screening

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*Functioning as joint case finders/monitors.

costs of approximately $20-$25.

These expectations assume screening team composition, case finder to eligible population ratios, and screening capacity utilization as indicated in this report.

2. In-Home Screening (Sector C)

Antecedents

Previous demonstration projects and most on-going EPSDT programs have experienced limitations on client participation not anticipated. Client participation rates (penetration rate) in excess of 50 percent were rare even with extensive outreach efforts involving program specific case finders. Most EPSDT on-going programs in the varying states were reflecting client participation rates in the area of approximately 30 percent, and these rates included a significant number of duplicate counts, wherein screens and rescreens (including the multiple infant rescreens) of the same child were often reported as reflecting different children.

In the demonstration projects, such as Dallas, with aggressive full time case finders employing in-home contact as a technique supported by reasonably responsive transportation and convenient fixed screening sites, participation rates of 50 percent were achieved (Phase 2 report). The questions, then, were "what is the probable maximum feasible participation rate in EPSDT," and "what means would be necessary to achieve the maximum rate.

One of the most cost effective means of achieving a major increase in participation may be a school focused EPSDT program for school age children. This was one of the planned tests for Phase 4 of the project, to determine the efficaciousness of this mode, which was deleted by the state. In the interim, in Phase 3, a modification of the home visit contact approach, which significantly increased the availability and accessibility of screening sites (neighborhood clinics) to within eight to ten blocks of homes, was then reflecting results indicating the possibility of a 65-70 percent participation rate. (Phase 3 Report). The question, nevertheless, still remained, though at a somewhat higher level than originally broached, "How were higher (maximum) participation rates to be achieved?" An in-home screening approach was proposed, based upon a project reported upon in the American Journal of Public Health by Dawson, Cohrs, Eversole, Frankenberg, and Roth, "Cost Effectiveness of Screening Children in Housing Projects".* This test was acceptable to the state with the constraint, however, that in-home screening be limited to only those clients who had twice previously (annually) been offered the opportunity for screening and who failed to participate in the program. By established project procedure this would have meant, for those who had previously agreed to participate in the

*Volume 66, No. 12, (December 1976) pages 1194-1196

program and accepted a screening appointment, up to six efforts to achieve a successful appointment, all of which would have been broken. Comprising this group would also have been those who had twice overtly refused to participate in the program.

Objectives (In-Home Screening)

The State's expressed major interest in "in-home" screening was to determine whether the children of the non-participating families were less healthy than those participating in EPSDT, and whether there were any programmatic or socio-economic barriers that had deterred participation that changes in policy or procedure might rectify. The Federal agency's (SRS/HCFA) interest was in the potentialities of the methods to maximize participation and its associated procedures, equipment, and costs.

Evaluation

These three interests are addressed as follows:

A. Status of Health of Children Screened in the Home

The sample size for in-home screening became so small that the results are not statistically conclusive. This situation developed because of the constraint imposed on the in-home test of two previous sequences of non-participation, and the unique and unanticipated level of success of the neighborhood clinics in stimulating program participation and concurrently reducing the number of repeated non-participants. Additionally, the test of this technique was limited to Sector C both by virtue of state guidelines and operational continuity.*

In summary, there were approximately 560 eligible families in Sector C as of the December 1977 DHR eligibility roster, of which 504 were successfully recruited prior to the institution of the in-home screening in late February, 1978. Twenty eight of the remaining 56 non-participating families moved or lost eligibility prior to the implementation of the in-home screening.

The remaining 28 families then eligible for in-home screen disposed as follows:

Received in-home screen	10 families	20 children
Not locatable**	12 families	
Refused	2 families	
Failed to keep appmt. (not at home)	3 families	
Already under care	1 family	
Total	28 families	

*In-home screening was designed as a continuum and extension of the neighborhood clinic approach which was sited in Sector C.

**Not at recorded or referred address

Only three of the twenty children screened had a medical problem. This is a 15.0 percent problem referral rate, whereas the same screening team operating in the mobile mode (neighborhood clinics) in the same Sector (C) found 24.5 percent with problems for referral.

Conclusion

Though not statistically significant, the implied finding that the children in this normally non-participating group were as healthy as those in the participating group was generally confirmed by the nurses conducting the screening. Their impression was that non-participation of these families in the EPSDT program was more of a judged lack of need rather than a lack of interest. This impression is also reinforced by the fact that only one (8 percent) of the 13 children under age six (preschool) out of the 20 screened was not "current for age" in immunizations. In the program participating group, this generally would have been six (45%) out of 13 children.

B. Barriers to Program Participation (See Appendix A, Sub Study, The In-Home Interview)

The complete report of the "In-Home Interview" is attached as Appendix A to this chapter. As already indicated, the unexpected success of the mobile teams (neighborhood clinics) in Sector C significantly reduced the non-screened (program rejector) population that was to be the focus of the in-home screen and survey.

Though the survey indicates that the programmatic barriers to program participation may still be those reported in a continuum of such studies, i.e., transportation and clinic waiting time, the neighborhood clinics served to indicate a means to overcome these barriers for a large proportion of those eligibles normally difficult to recruit.

As a separate but related and equally important issue, however, there are indications that the difficult mothers to recruit may be the younger, less experienced parents, that are single, less educated and unemployed. This complex of characteristics has repeatedly been shown in the literature to be highly related to problems of recruitment to and continued use of health services. This suggest one possible approach to prioritization of case finding.

C. The Mode and Efficacy of In-Home Screening

Impact of In-Home Screening on rates of Program Participation

The extreme intensity of case finding effort in Sector C ultimately

produced contact with 90 percent of the eligible families prior to the in-home phase. The in-home phase increased this to 93 percent, which is considered the maximum feasible level of family client contact due primarily to frequency of moves (changes in address) by eligible families. (See Table 4 - Length of Time at Current Address)

The rate of family contact should not, however, be confused with the participation rate which is based upon program participation of the children. Quite frequently, mostly due to various ages of children in a family, e.g., pre-school, school, etc., only one or two of three to four or more children in a family will be successfully brought into the program. Therefore, it is quite feasible to achieve a 90 percent rate of family contact and only a 50 percent participation rate of the eligible children. The rate of participation in Sector C ultimately reached 60 percent, with an estimated 70 percent potential.

Outreach For In-Home Screening

The original concept of outreach to support "in-home" screening was to send a letter to "in-home" eligible families two to four weeks in advance of the planned visit informing the client about the EPSDT program and advising that in the immediate future screening teams would be in the neighborhood to do medical screening in the homes. One day prior to the team visit, or on the same day, it was intended to precede the team visit by a case finder visit to homes to establish contact, obtain acceptance, and develop a specific schedule for the screening team. The original concept also planned to employ the case finder/screening team group within a compact geographical area (neighborhood/block) on a day by day basis. This concept presumed that almost 30-40 percent of the eligibles in the area would have been program non-participants and that such an organized block by block/neighborhood by neighborhood approach would be justified by the numbers of clients still to be recruited.

The technique actually employed retained the preliminary letter notification, but totally eliminated the preliminary case finding contact. The team, employing a list of eligibles with specific addresses, would go directly to the homes. In many instances the client would not be at home and repeat visits would be required. Up to three visits would be made in an effort to establish the contact and execute a screen. It was this "waste" of the screening teams' (nurses) time in non-productive visits that the original procedure intended to avoid.

If the client "answered the door" they were asked if the children could be screened. If rescheduling was necessary because the children to be screened were not at home, or the parent(s) were not home to give permission, or the time was not then convenient to the client, a subsequent appointment would be set for that or the following day.

If no contact could be made after three attempts, a note was left or mailed explaining the purpose of the visit and informing the client that by calling they could arrange a time for their child to be screened in their home.

In-Home Screening - Team Composition

The screening team consisted of two persons: 1.) a registered nurse (Nurse III) (Family Nurse Practitioner) and 2.) a Case Aide (III) who was indigenous to the area. It had been determined in advance that this was the maximum number of people that could practically be accomodated in a small apartment or crowded house. The duties of the aide consisted of completing forms* and taking a health history. (Items 1-148 Texas Department of Health Screening Form--#400)

It was originally planned for the aide to assist with the screening measurements (vision/hearing testing), but with the length of time required to execute the data collection it was determined to be more effective to have the nurse execute all components of the examination, per se.

This team structure and function distribution appeared to work quite satisfactorily in conducting the in-home screen.

Supplies and Equipment - In-Home Screen

The supplies and equipment utilized in the in-home screen were mainly carried in a typical salesman's sample case that was 12" high x 8" in depth x 18" in length and weighed 16 pounds when complete.

The items carried in the case were:

12 copies of Denver Developmental Screening Test
12 copies each of forms - Screening (Form 400)
Project Supplemental Data Sheet
Problem Referral Sheets
Consent Forms
Stethoscope
Ophthalmoscope
Tongue depressors
Laboratory supplies:

special collecting vials	urine test strips
lancets	paper cups
masking tape	alcohol
bandaids	cotton swabs

Light weight scale
Worth 4 Dot Flashlight
Pen light and flashlight
Eye Chart

*Project Data Sheet, Screening Record, Problem Referral Sheet and Consent Form.

Sphigmomanometer
Carpenter's ruler
Balloons/lollipops

Additional items carried, but not a component of the case, were the audiometer and immunization vaccines (normally transported in an ice chest in the car).

All of these items were easily carried by both members of the team. These items were all the same as used in the regular mobile clinic with the exception of the eye chart which, for the in-home screening, was for 10 feet (the smaller Snelling Chart) viewing rather than the normal 20 feet.

The transportation utilized was either the project van or one of the team members cars.

Client Response to In-Home Screening

The clients contacted (actually reached at home) were very responsive and cordial. Only two families actually contacted refused the service. Therefore, it appears that in this group, as well as in the previously discussed group of participants, a major obstacle exists in obtaining a contact with the client, rather than obtaining consent to participate once the contact was made.

A factor underlying their previous non-participation in EPSDT appears to be that many felt they were adequately within the mainstream of the on-going health care delivery system--for acute episodic care. In another sense, it might be said that the mothers were satisfied with the health of their children.

Workload Factors and Costs - In-Home Screening

The project screening team operating in their regular mode (neighborhood clinics) indicate a screening capability of 60 screens per full clinic day. As indicated in Chapter V, the cost of a project "screen", per se,* in the mobile clinic mode is $19.40 per screen.* The cost for the City of Dallas Screening Team for a screen is in the range of $22-$25* per screen.

The in-home estimate is a screening capability of 15-20 children per day, or approximately seven successful family contacts (assumes 2.5 children per family to be screened). The cost per screen is $47.98 in the in-home mode. This increased cost per screen in the overall is offset somewhat by the materially reduced case finding cost if conducted in this

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*Excludes case finding, diagnosis and treatment, and case monitoring costs and does not fully reflect state level and other infra-structure type supporting costs.

mode (in-home screen visit without prior family contact). This approach (no prior personal contact) would not be recommended in a situation where the group of eligibles would be highly concentrated in a tight geographical area. This density of eligibles was expected to prevail for these "in-home" tests, but because of the other factors previously discussed, the eligibles became quite limited in number and quite dispersed in location. Estimated case finding costs associated with this mode of screening would be expected at approximately $30 per child screened.

Conclusion:

In-home screening is a feasible means of attaining EPSDT program participation by eligibles who are normally resistent to the program. Its total medical related costs* are approximately $111, and medical and dental related costs $143, compared with the mobile clinic costs of $80 for medical related and $112 for medical and dental.

The result in this project of achieving exceedingly high rates of program participation by means other than in-home screening and the "good" status of health of those children in the normally considered most difficult families to recruit to the program indicate that the "in-home screen" method of case finding should only be utilized in unusual circumstances.

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*Including case finding, screening, diagnosis, treatment and case monitoring.

3. COMPASS (Comprehensive Patient Assistance) Sectors A and B

Antecedents

The earlier phases of case finding activity in these sectors were mainly concerned with testing the home visit method of contact to "recruit" participation for the EPSDT program. These efforts were carried forward by both full time and split time* case finders of various skill categories. The efforts were associated with the city of Dallas EPSDT screening teams functioning out of two primary established sites (Harris Center/Lion's Club Clinic) and supported by TDHR contact transportation.

The primary results obtained from these efforts and recorded in detail in the Phase 2 and 3 reports were a range of "kept appointment" rates of from 63 to 70 percent, and a potential population participation rate of 45-50 percent.

Concurrently with these efforts, the Texas Department of Human Resources contracted with the Inman Christian Center, a non-profit community organization, in San Antonio, Texas, to provide outreach and follow-up services in support of the EPSDT program. The health related sub-systems of EPSDT were quite similar to those in Dallas, i.e., screening executed by the city health department (San Antonio Metropolitan Health District) on a fixed schedule in sites supportive of the broader target populations, with diagnosis and treatment most often by referral to the private sector.

The Inman Christian Center serves an almost totally Mexican American population of roughly 8,000 children in two zip code areas in the barrio of San Antonio.

The main thrust of Inman Christian's approach is the use of case finding/case monitoring aides who are bilingual women with families of their own living in the designated areas of the barrio. Educational prerequisites are minimal and not significant.

The technique employed is maximum personal contacts in the home, or other points of community gathering, with frequent follow-up by telephone (if available), and home visit. The aides inform the parents concerning the free screening and treatment services, and their value to the children. The aides offer the full use of the free Inman Christian transportation to both screening and treatment. The aides accompany the transportation to the home, and the parent and children to the screening appointment, and will often provide similar service to treatment providers. Generally, up to three efforts will be made to achieve a "kept appointment."

The Inman Christian Center has consistently reported uniquely high "kept appointment" rates for screening of 80-90 percent.

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*Time split between case finding and case monitoring

Since the outreach methodology of Inman Christian and that employed in Sectors A and B by the Dallas project were seemingly similar, a question arose concerning the difference in results (rate of "kept appointments") i.e., Dallas 63-70 percent, and Inman Christian 80-90 percent. Close scrutiny identified that methodologically there were two differences in the respective approaches. One, the Inman Christian transportation was under its direct control, and highly responsive to client needs, whereas the Dallas transportation was by contract covering the whole city of Dallas for a multitude of social service requirements. It was less individualized and responsive. Two, the workers in Dallas were public sector employees whereas the workers in Inman Christian were contract workers. The former are generally more highly controlled by rules and regulations and have little flexibility in fashioning their work programs, whereas the latter are often afforded appreciable latitude in tailoring their work programs and may even be stimulated by work incentive programs and incentive payments, etc. which are rarely permissable in structured public sector organizations.

Objective

The COMPASS variable was established with the express purpose of maximally replicating the Inman Christian methodology and attempting to achieve the same results.

As indicated, the major existing methodological difference was transportation. In the COMPASS approach a project van was added to the existing transportation to provide more responsive transportation. The van was to respond to persons missing the regular transportation or making "late" request for transportation. The regular transportation made home pick-up if scheduled in advance, and generally allowed itself a thirty minute leeway in scheduled pick-up time in this project phase. This approach on transportation, though more responsive than in the earlier phase, was still not fully replicative of Inman Christian's in-house transportation.

Results of COMPASS

A. Number and Rate of Screening Appointments Made and Kept, 1st 2nd, and 3rd Appointments by Time Period in Sectors A and B

Time Period	Worker Category	Sector	Number Child. Apptd. Screen	Number Keep First Appmt.	Rate Keep First Appmt.	Number Apptd. Keeping 2nd Apot.	Cumulative Rate Keeping 1st & 2nd Appt.	Number Apptd. Keeping 3rd Appt.	Cumulative Rate Keeping 1st,2nd & 3rd Appmts.
Phase 2 Aug.- Dec. '76	PWWI CF	A & B	613	272	44%	87	59%	26	63%
Phase 3 Feb.- Jun.'77	PWWI/ CSA III CF/CM	A & B	901	397	44%	126	58%	82	67%
Phase 4 (COMPASS) Jul.- Dec.'77	PWWI/ CSAIII	A & B	722	379	52%	92	65%	40	71%

B. Rate of Program Participation (Penetration Rate)

COMPASS-SECTORS A & B** IN THREE PERIODS OF TIME

Time Period	In Sectors A & B as of: Dec.31,76	Jun.30,77	Dec.31,77	Who Showed for Screening as of: Dec.31,76	Jun.30,77	Dec.31,77	Annualized Projected Shows for Screen (Penetration Rate) No	Rate	Annualized Average Projected Case Find FTE's Available
Phase 2 Aug.'76- Dec.'76 (5 months)	2658			375			900	33.9%	1.92
Phase 3 Jan.'77- Jun.'77 (6 months)		2599			518		1036	39.9%	2.53
Phase 4 (COMPASS) Jul.'77- Dec.'77 (6 months)			2690			568	1136	42.2%	2.85

*Data derived from Family Contact File

**Data derived from Texas DHR Monthly Eligibility Tapes and HSRI Screening files.

Discussion

As is obvious from the above data, the transportation addition to the existing outreach procedure only minimally increased the "kept appointment" rate of the three appointment attempts from 67 percent to 71 percent, and the potential penetration (participation) rate from 40 to 42 percent. This "kept appointment" rate fell short of the Inman Christian reported rate of 80-90 percent. There was no basis available to the HSRI to attempt a penetration rate comparison of Inman Christian.

At issue, then, is whether the Inman Christian Center outreach methodology has broad applicability with any assurance of replicability of its rates, or whether the Dallas project results are more likely to be realized in a replication.

It has been suggested that the added increments of performance success in the "kept appointment" rates by Inman Christian Center is a result of unique homogeneity between the Center, its workers, and the target population. All are highly identified with the Mexican American culture; the workers are bilingual women who live and rear families in the "barrio."

Also, as earlier stated, the impact of "public sector" versus "contract" worker needed to be isolated from the issue to arrive at a reasonable valid conclusion. An opportunity existed to accomplish this in that TDHR had also contracted with another community organization in San Antonio, Health, Inc., to provide outreach/follow-up services in support of the EPSDT program to a population of approximately 5,000 predominantly Black children in four zip zones. The personnel of Health, Inc. show a racial identification with their major clientele as did the outreach workers in the Dallas project, and Health, Inc. utilizes outreach and follow-up techniques similar to the Dallas project and Inman Christian. Health Inc. reports a 55-65 percent "show for screen" rate which is reasonably comparable with the Dallas project rate.

Conclusion

The similarity of results between the Dallas project and Health Inc. suggests that the higher rates achieved by Inman Christian may be primarily a result of a homogeneity that exists in the Mexican American Culture and generally not in the Black or Anglo culture.

It is, therefore, reasonable to postulate that the Dallas project technique employed in Sectors A and B as public sector activity or utilized by contract community organizations will produce similar results if replicated in most other urban centers. It is also appropriate to postulate that the Inman Christian approach may produce similar results when applied to other tightly knit ethnic communities such as the Mexican American community in El Paso, Texas; Los Angelos, California; the Cuban community in Miami, Florida; and even perhaps the Puerto Rican community in Spanish Harlem in New York. All of these locations are urban centers of high density EPSDT eligibility.

4. MIC (Maximum Interagency Coordination)

Antecedents

Interagency coordination to reduce duplication (overlapping) of services to children has become a major federal objective for the EPSDT program. This objective was incorporated in the Dallas project for its third year.

Objective

The objective was to develop a protocol between selected agencies in the Dallas area to serve as a model for possible utilization statewide.

Discussion

It was presupposed that the development of a local model would involve participation of concerned state level agencies at all critical points of discussion. In time, the goal became to "design and pilot test a method of adding screening sites to improve the penetration rate of the Title XIX eligible population, thus reducing duplication of services by contracting and coordinating with an agency already serving part of the EPSDT clientele."

The agency selected and willing to participate in this activity was the Southwestern Medical School Division of Maternal Health and Family Planning.

The issues that involved considerable discussion in the negotiation were confidentiality, reimbursement, forms flow, screening staff, outreach and follow-up mechanisms, and responsibilities. The status of discussion in these areas at the time of completion of this report was as follows:

Confidentiality:

There are two areas of confidentiality that should be defined: (1) The EPSDT recipients would need to be identified before screening to insure the appropriate screening techniques. Eligibility could be determined by having printouts sent to Family Planning offices or data bank confirmation by mail on a regular basis. (2) In case of a medical referral, the social worker would not reveal the source of the screen.

Forms Completion and Flow:

The required forms will be completed at the time of the Family Planning health examinations. Each examination should have a record of the activity by completion of the form documenting medical history and screen results. Any person requiring a medical referral should have an additional form completed to enable Department of Human Resources to place the information in the computerized case management system. These forms are one method of meeting HEW requirements. The actual forms flow would be arranged by contract.

Standards

The screening package of Family Planning would be expanded to meet the standards of an EPSDT screen.

Outreach

Outreach could be reduced by the Department of Human Resources as the eligible recipients return for the regular Family Planning exam and the EPSDT screen. Duplication of outreach and screening could be avoided.

Follow-up

Follow-up technique for the medical referrals found at the time of the FP/EPSDT Screen would require negotiation. Both Family Planning and the Department of Human Resources have social workers for following medical and social problems. In other contracts, such as Inman Christian Center, the follow-up on medical referrals is the responsibility of the agency contracting with DHR.

An outline of a structure for possible integrated services between EPSDT and Family Planning activities in the Dallas area was developed.

Conclusion

Contact and reimbursement of agencies currently performing some elements of EPSDT type services under other programs, e.g., Family Planning, to provide the complete EPSDT package of services and report such services to the EPSDT agency appears to be a feasible course of action.

The number of manhours required to develop such arrangements by all parties concerned, however, appears as a logical deterrent to significant progress in this overall area.

APPENDIX A

THE IN-HOME INTERVIEW

In conjunction with the in-home screening project, a special study was undertaken to determine social-psychological and sociodemographic characteristics of program acceptors (i.e., clients whose children were screened) and program rejectors (i.e., those who refused screening for their children and those who initially accepted but failed to keep appointments). The research built on numerous previous studies of both program and client characteristics influencing refusal to participate in a program and broken appointment rates (cf., e.g., Badgley, 1961; Alpert, 1964; Stine, 1968; Hurtado, 1973). Such program remedial factors as clinic location and time of operation, lack of transportation, child care needs, and cultural and language differences between health care personnel and clients have been identified. Relevant client characteristics have included low socioeconomic status, low educational level of the mother, a sense of helplessness or fatalism and an associated lack of preventive planning, rural-urban background, and marital status, among others.

Many program modifications suggested by the findings of these studies had been incorporated in the delivery approach of the Dallas EPSDT Project. Indigenous outreach workers, letters of reminder, transportation service, and mobile neighborhood sites were being used. While a majority of those eligible in the project area responded to these efforts by having their children screened, a small residual did not. Before such children were to be screened at home, attempts were made to interview their mothers and a control group of program acceptors to determine whether there were significant differences between the groups that might suggest further modifications in the delivery approach that would reduce the number of program rejectors.

Methodology

Families to be interviewed were selected from the following groups of program eligibles:

	Total Eligible Families	Sample Size	Number Interviewed
A. Those contacted in both 1976 and 1977 but not screened (in-home eligible)	25	25	15
B. Those contacted in 1977 but not screened (in-home eligible)	25	25	17
C. Those contacted in both years but screened only in 1976 (partial rejectors)	15	15	9
D. Those partially screened in 1977 (partial rejectors)	15	15	9
E. Those screened in 1977 (control)	408	45	35

Non-response was due primarily to an inability to locate families because they had changed residence; there were no refusals. The find rate of 68 percent resulted in a total sample size (N = 85) considerably smaller than desired. For the purpose of analysis, groups A and B (families eligible for in-home screening) and groups C and D (partial rejectors) were collapsed.

A short questionnaire, designed to elicit the following kinds of information, was used:

1) sociodemographic data;
2) knowledge and use of EPSDT services;
3) health status and use of other health care services;
4) program and situational barriers to health care utilization; and
5) attitudes toward prevention in matters of general health.

A copy of the questionnaire is appended. It was pretested in the fall of 1977; interviewing began in January 1978, and continued for about two months until the end of March 1978. Three interviewers, a male and two females, were hired at the outset. Attrition among interviewers was high, making it necessary to employ another female several weeks after interviewing had begun. Eighty-two percent of the interviews were conducted by one interviewer.

Findings

Table 1 shows selected sociodemographic characteristics of the study families. While the three groups were very similar in terms of average family size, as measured by the number of persons per household under 21 years of age, they differed in other important respects. Interestingly, mothers in the in-home and control groups closely resembled one another: they were somewhat older on the average than the partial rejectors and a substantially smaller proportion of in-home and control mothers than partial rejectors were themselves under 21. A majority of all respondents--about one-half of the in-home and control mothers and almost 80 percent of the partial rejectors--reported their marital status as "single". Approximately 23 percent of the mothers in the control group said they were "separated", and 28 percent of those in the in-home group said they were "divorced". Less than one-half of the mothers in any of the three groups had completed high school; only one-third of those in the partial rejector group had done so, but more of them were currently enrolled in a school program. A smaller proportion of partial rejector than in-home or control mothers reported to an interviewer that they were currently employed, either full or part-time (11.1 versus 21.9 and 17.1 percent, respectively). With the exception of one Spanish surname mother, all of the respondents were Black.

Table 2 summarizes information elicited about the respondents' knowledge of EPSDT based on contact with an outreach worker, conversations with friends or relatives, and/or personal experience with such services provided at Martin Luther King and/or the mobile neighborhood site near which the family resides. Although all of the families had at sometime in the past been visited at home by an outreach worker to talk about having their children screened, only about 83 percent of the mothers in the control group recalled this visit; even fewer of those in the in-home and partial rejector groups recalled it (68.8 and 61.1 percent, respectively). When asked, in an open-ended manner, "What have you heard about

the health clinic at [MLK or the mobile site nearest their home]?", mothers in the partial rejector group most frequently responded "nothing" or "not much" (58.8 percent); about 36 percent of the mothers in the in-home group and only 25 percent of those in the control group so replied. The most frequent answer given by mothers in the control group was "It's good" or "It's fine" (34.4 percent); almost 30 percent of the mothers in the partial rejector group responded with these or other similar positive statements. While such responses are positive and indicate general approval of the services, they are nonetheless vague and the likelihood that they were given in response to subtle demand characteristics of the interview situation cannot be ignored. Mothers in the in-home and control groups demonstrated more precise knowledge than those in the partial rejector group of what EPSDT services are all about: without probing, 29 percent of the in-homes and 22 percent of the controls said "They give children a complete physical [check-up or exam]"; an additional six percent of the controls used the word "screen" to describe the services given. Small proportions of mothers in the in-home and control groups mentioned that they had heard the services were "free" (6.5 and 12.5 percent, respectively) and/or that dental as well as medical services were provided (12.9 and 3.1 percent, respectively). Almost 10 percent of the mothers in the in-home group said they thought the clinic was for "shots" only, probably indicating their confusion about well-baby care, EPSDT, and other services offered at MLK. None of the mothers in the partial rejector group and only small proportions of those in the in-home and control groups mentioned negative things about MLK; these were primarily complaints about the long waiting time.

When the general question "What have you heard . . .?" was followed with specific probes, response patterns emerged which seemed highly related to a family's actual experience with EPSDT services at MLK or a mobile site. Thirty percent of the mothers in the control group, for example, answered that the services were primarily nurse-centered when asked "Do you know what kinds of people work at the clinic?" Almost 90 percent of these mothers could describe the "kinds of health problems they check for": about 24 percent said "everything", "all kinds of problems"; 15 percent mentioned one kind of problem ("childhood diseases", "TB", "teeth"); and almost one-half were highly specific in their description of the screening process. The following phrases illustrate the latter:

> ". . . eyes, weight, blood, urine"
> ". . . ears, infections, eyes, disease, blood test"
> ". . . blood, teeth, eyes, reflexes"
> ". . . ears, eyes, blood pressure, throat, teeth, stomach, back, urine, problems, pain".

Regardless of program acceptance status (i.e., whether in-home, partial rejector, or control), all respondents were asked whether or not they had ever taken their children to MLK or a mobile site to be screened. Table 3 shows the answers to this question and a series of related ones. Although clinic records indicated that no children in the in-home group had been screened, more than one-half of these mothers stated that they had; also unexpectedly, a high proportion but not all of the mothers in the control group said their children had been screened. About 37 percent of the in-home mothers who reported taking their children to be screened said that all, not just some, of their children had been screened, that in 27 percent of these children, conditions needing

treatment were detected, and that in about two-thirds of these cases, the conditions were not yet resolved. We can only speculate about the meaning of these results: problems of recall may account for the fact that not all mothers in the control group remembered having had their children screened. It is more difficult to explain why over one-half of the in-home mothers reported their children had been screened: errors in clinic records are possible but an unlikely explanation for the number of such cases encountered; social desirability and acquiescence problems deriving from the interview situation may account for the findings; confusion between an EPSDT screen and other check-up or well-baby care a child may have received at MLK or elsewhere is a probable contributing factor.

While we cannot be certain that the satisfaction with services expressed by 91 percent of the in-home mothers refers to an EPSDT screen, it is notable that 94 percent of those in the partial rejector and control groups who reported that one or more of their children had been screened felt it was worthwhile. About one-quarter of the mothers in each of these two groups felt the screen was worthwhile because "they found problems"; about one-half in each group mentioned the importance of preventive check-ups--"because when you go early, maybe you live longer" and "because things can be wrong that don't show" were typical statements; about one-sixth in each group mentioned that the screen was worthwhile because "the examinations was more thorough than at the doctor", "they take so many tests", "the check-up was good", and similar remarks. The typical reason given by those who felt the screen was not worthwhile was "because the children are in good health".

If such a high level of satisfaction with the screen was expressed by mothers in the partial rejector group, what are the reasons not all eligible children were screened or that children were screened in 1976 but not in 1977? While we cannot arrive at a definitive answer to this question with the present data, Tables 4 through 6 suggest a possible line of reasoning. Table 4 shows responses to the question "Are there any things that make it difficult for you to take your children to the clinic at MLK or to the mobile site?" The problem most frequently mentioned by mothers in the partial rejector and control groups was transportation; for those in the in-home, it was waiting time. About one-fifth of the mothers in all groups said clinic hours were a barrier to use of the services: scheduling presented special problems for mothers in the in-home group, 22 percent of whom said they would have to miss work to take their children to the clinic. Child care presented substantially greater problems for mothers in the in-home and partial rejector groups than for the controls, despite the fact that mean family size and age composition of children in all groups were similar (Table 1). In cases of family problems or when one needs someone with whom to talk, the mothers in the partial rejector group more frequently than others said they had no one upon whom they could call (33.3 percent versus 18.8 and 5.7 for the in-home and control groups, respectively). They also demonstrated somewhat greater feelings of fatalism--helplessness or lack of control--over matters of general health (see Table 5). While, with one exception, their responses to four items that measured this dimension were less fatalistic than those in the other groups, when a composite scale score was computed for each respondent, about 28 percent of the mothers in the partial rejector group as compared with 22 percent and 11 percent in the in-home and control groups, respectively, could be considered "highly fatalistic". Fatalistic attitudes, which have been shown to be associated with

the use of preventive health services (Morris, et al., 1966; Gray, et al., 1967), were, as predicted, highest among mothers in the in-home and partial rejector groups.

Table 6 presents findings on patterns of health care utilization behavior which seem to correlate with the observed social-pshchological attitudes of the respondents. Fewer mothers in the partial rejector group than others reported having had a check-up or seeing a dentist within the past year, and a greater proportion said they had received no prenatal care during their last pregnancy. While the proportion of mothers in partial rejector and control groups was very similar, all of the former and only one-half of the latter had visited a dentist for strictly curative reasons (toothache, etc.). The proportion of families in the partial rejector group in which at least one child had seen a dentist within the past year was one-half as great for those in the in-home and control groups (16.7 versus 31.3 and 37.1 percent, respectively).

There were no significant differences in incidence of illness within the three months prior to interview among mothers in the different groups; mothers in the partial rejector or control groups were only somewhat more likely than those in the in-home group to have received treatment when they were sick. Substantially fewer of the children in families in the partial rejector group than others had reportedly been sick at any time in the three months prior to interview and, of these, all had received treatment. Most mothers in the in-home group depended upon private physicians for advice and treatment of sick children; mothers in the control group relied about equally on private physicians and on Parkland or Children's Medical; those in the partial rejector group most frequently used "Dallas Osteopathic" and "Forest Avenue" Hospital and "Cedar Crest", and showed the least reliance on private physicians, though they reported more frequently than mothers in the other groups that they had a "family doctor".

Summary and Conclusion

Because of the small sample size, the findings of this study cannot be generalized with any certainty. However, the interesting differences between in-home, partial rejector, and control families which were found suggest a need for further study, possibly of a prospective nature. to develop criteria for prioritizing case finding.

Surprisingly, mothers in the in-home and control groups, whom we had expected to be quite different, were similar in many regards. Mothers in the partial rejector group, on the other hand, were younger, less experienced parents, more of whom were single, less educated, and unemployed. They seemed more than others to feel that they had little control over their lives or their health (i.e., they were more fatalistic) and they were least likely to feel that they had someone upon whom they could call in times of trouble. This complex of characteristics displayed by the partial rejectors has repeatedly been shown in the literature to be highly related to problems of recruitment to and continued use of health services. Consistent with this, mothers in the partial rejector group had received less preventive care than others in the recent past and they

demonstrated the lowest level of knowledge of EPSDT services. For this group of mothers, such personal factors appeared to be the most important barriers to the use of health services; for mothers in the in-home group, program factors (i.e., transportation, waiting time) presented the greatest obstacles to screening.

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Table 1

Sociodemographic Characteristics of the Study Families

	In-Home (N = 32)	Partial Rejectors (N = 18)	Control (N = 35)
Mean number of persons in household under 21	2.9	2.8	3.0
Age of mother (or caretaker*)			
Mean	31.7[a]	25.6	31.3[a]
Range	18-75	17-49	15-80
% Under 21	21.9	35.3	21.2
Marital Status			
% Single	50.0	77.8	54.3
% Married	6.3	--	8.6
% Separated	15.6	5.6	22.9
% Divorced	28.1	11.1	5.7
% Widowed	--	5.6	8.6
Education			
% Completed 12 or more grades	45.2	33.3	44.1
% In school	6.3	27.8	17.1
% Currently employed	21.9	11.1	17.1

*In four cases, caretakers were grandparents.

[a]Mean significantly different from that of the partial rejectors at the .05 level.

Table 2

Knowledge of EPSDT Services

	In-Home (N = 32)	Partial Rejectors (N = 18)	Control (N = 35)
% Recall home visit by outreach worker to talk about screening	68.8	61.1	82.9
What respondent has heard about screening site*			
% Nothing	35.5	58.8	25.0
% "It's good", or other positive response	12.9	29.4	34.4
% Check-up, exam, or complete physical	29.0	5.9	21.9
% Screen	--	--	6.3
% Free	6.5	--	12.5
% Dental services	12.9	--	3.1
% Shots only	9.7	--	--
% Negative responses	3.2	--	6.3
How clinic is staffed			
% Nurses	6.5	22.2	30.0
% Nurses and Doctors	48.4	38.9	66.7
% DK	45.2	38.9	3.3
Types of problems for which they check			
% Everything, complete physical	22.6	16.7	24.2
% Mentioning one problem	12.9	--	15.4
% Mentioning several problems	16.1	33.3	48.5
% DK	48.4	50.0	12.1
Cost			
% Nothing	19.4	22.2	27.3
% Based on income	3.2	--	--
% DK	77.4	77.8	72.7

*Proportions do not sum to 100 because of multiple responses.

Table 3

The Screen

	In-Home (N = 32)	Partial Rejectors (N = 18)	Control (N = 35)
% Had ever taken children to be screened	53.1	83.3	94.3
% Who took all children for screen	36.8	81.3	85.3
% In which problems were found	27.3	17.6	41.2
% In which problems not yet resolved	66.7	100.0	46.2
% Who thought screen was worthwhile	90.9	94.1	94.1

Table 4

Barriers to the Use of Health Services

	In-Home (N = 32)	Partial Rejectors (N = 18)	Control (N = 35)
Reported problems			
% Transportation	34.4	27.8	40.0
% Child care, if more than one child	15.4	21.4	3.3
% Waiting time	40.6	16.7	22.9
% Missing work	21.9	11.1	8.6
% Clinic hours	18.8	22.2	17.1
Person to call on in case of family problems			
% No one	18.8	33.3	5.7
% Friend	12.5	16.7	25.7
% Relative	68.8	50.0	68.6

Table 5

Social-Psychological Attitudes Toward
Health and Health Behavior

	In-Home (N = 32)	Partial Rejectors (N = 18)	Control (N = 35)
Do you feel that people who watch what they eat and take care of themselves stay healthier than those who do not, OR do you think that good health is more a matter of luck?*			
% Fatalistic responses	16.1	6.3	23.5
Do you think it is possible for people to plan how many children they will have, OR are there too many things that can happen to mess up those kinds of plans?*			
% Fatalistic responses	58.6	50.0	39.4
Do you feel that people will die when it is their time and there is not much that can be done about it, OR that by taking good care of their health people can generally live longer?*			
% Fatalistic responses	43.8	58.8	40.0
Do you think that it is worthwhile for people to get checkups when they are well, OR that nothing much can be done to prevent most illnesses?			
% Fatalistic responses	9.7	6.3	5.7
% Highly fatalistic	21.9	27.8	11.4

*Bullough (1972).

Table 6

Health Status and Health Care Utilization

	In-Home (N = 32)	Partial Rejection (N = 18)	Control (N = 35)
% Mothers (or caretakers) sick in the past 3 months	31.3	33.3	34.3
% Sick mothers who received treatment	60.0	66.7	66.7
% With children sick in the past 3 months	59.4	33.3	60.0
% With sick children who received treatment	68.4	100.0	81.0
Place children treated			
% Private doctor	69.2	16.7	41.2
% Parkland/Children's Medical	30.8	33.3	41.2
% Other	--	50.0	17.6
% Mothers who had a check-up in the past year	40.6	33.3	42.9
% Mothers receiving no prenatal care during last pregnancy	10.0	16.7	12.9
% Mothers who had seen a dentist in the past year	28.1	16.7	17.1
% With at least one child who had seen a dentist in the past year	31.3	16.7	37.1
% With family doctor	59.4	61.1	48.6
% Who depend on Parkland in cases of serious illness	76.9	85.7	66.7

Interview Number:_____

1. Are you (name of respondent)?

   ____Yes ——→ SKIP to #3.

   ____No

2. Are you her mother, or do you help to take care of her children?

   ____Yes ——→ (RECORD relationship:_____)

   ____No

   (ASK when respondent can be found at home, and then end interview).

3. INTRODUCTION: Good morning/afternoon. My name is _____ and I am working for The University of Texas Medical School. We are interviewing people in this neighborhood about their use of (interviewer to supply name of screening site) during the past year and we would like to ask you some questions about this. The interview will take about 10 minutes. Your name was given to us by the Welfare Department, but your participation in this study will not affect your eligibility for health and social services. Your answers will be completely confidential.

4. Is there anyone living here who is under 21?

   _____Yes

   _____No ——→ (PROBE: Even counting yourself, there's no one under 21?)

   ____Yes

   ____No ——— End interview

5. How many are there under 21?_____

6. How old are they?

   1. _____

   2. _____

   3. _____

   4. _____

   5. _____

   6. _____

   7. _____

   (INTERVIEWER: if number is less than given above, PROBE for missing ones).

7. In the past year, do you recall anyone from the Welfare Department visiting you here at home to talk to you about having a medical checkup for your children at (interviewer to supply name of screening site)?

____ Yes

____ No ⟶ Did anyone at the Welfare Office talk to you about a checkup at (_____) for your children?

____ Yes

____ No

8. What have you heard about the health clinic at (_____)? (Record verbatim).

_____

_____

_____

IF NOT MENTIONED, PROBE: Do you know what kinds of people work at the clinic?

____Yes ⟶ Who? ____Nurses only
____Doctors only
____Doctors and Nurses

____ No

Do you know what kinds of health problems they check for?

____ Yes ⟶ What kind?_____

____ No

Do you know how much it costs?

____ Yes ⟶ How much?_____

____ No

9. Has anyone invited you to take your children to (screening site) to have a checkup or to be screened?

____ Yes

____ No

10. Have you ever taken your children to (_____) to have a checkup or to be screened?

____ Yes

____ No ⟶ Have any of your children ever had a complete checkup (physical examination when they were not sick) at any other location?

____Yes ⟶ Where?

____No ⟶ SKIP to Question #16.

11. Did all of the children go, or just some of them?

____All

____Some

12. When was the last time they had a screen or checkup?

_____

13. Did they find any health problems that needed to be treated?

____ No ⟶ SKIP to Question #15.

____ Yes ⟶ What did you do about this (these)? (Record Verbatim).

_____

_____

14. Is the problem completely fixed up (treated) or does your child still have the problem?

____ Completely treated

____ Still a problem

15. All things considered, would you say that it was worthwhile for you to have taken your children for a checkup or to be screened?

____ Yes ⟶ Why? _____

____ No ⟶ Why not? _____

16. Are there any things that make it difficult for you to take your children to the clinic at (_____)?

____ No

____ Yes ⟶ What? _____

_____

(PROBE: Anything else?)_____

IF TRANSPORTATION is NOT mentioned: Is transportation a problem?

____ Yes

____ No

IF CHILD CARE is NOT mentioned: Is it difficult to take the children to the clinic because there is no one else to take care of the other children?

____ Yes

____ No

IF WAITING TIME is NOT mentioned: Are you concerned that you will have to wait a long time at the clinic before your children see a doctor or nurse?

____ Yes

____ No

IF MISSING WORK is NOT mentioned: Do you have to miss work to take your children to the clinic?

____ Yes

____ No

IF CLINIC HOURS are NOT mentioned: Is it a problem for you to take your children to clinics which are only open on weekdays from 8 to 5?

____ Yes

____ No

17. Have you or any of your children been sick in the past three months?

____ No

____ Yes ⟶ Who? (Record ages.)

What was the matter? (Record Verbatim.)

Did the child receive any treatment because of this? (Circle.)

IF YES, By whom or where?

IF NO, Why not?

Yes No	Yes No	Yes No	Yes No

18. Have you yourself had a complete checkup (physical examination when you were not sick) in the past year?

____ Yes

____ No

19. Were you seeing a doctor during your last pregnancy?

____ No

____ Yes ⟶ In what month did you first see the doctor? _____

How often did you go after that? _____

20. Have you or any of your children been to a dentist in the past year?

____ No

____ Yes ⟶ Who? (Record ages.)

Did they go because of a toothache or was this a routine checkup? (Circle.)	tooth-ache checkup	tooth-ache checkup	tooth-ache checkup	tooth-ache checkup

21. Do you have a family doctor--a doctor that your children see regularly or on whom you can depend when they are ill?

____ Yes

____ No ⟶ If one of your children were ill and you felt they needed to see a doctor, where would you go first for help? _____

_____

22. In the case of the serious illness (broken bone or another emergency) of one of your children, where would you go first for help? _____

_____

23. How do you usually get your children to the doctor? (PROBE, IF NECESSARY, family automobile, neighbor's automobile, bus, etc.) _____

_____

24. IF THERE IS MORE THAN ONE CHILD IN THE HOME, is there someone else here like a grandmother or an older sister to care for your other children when one of them is sick and needs to go to a doctor?

____ Yes ___ Who? (RECORD relationship) _____

____ No

25. Do you have someone that you can call upon for help in case of family problems, accident or illness?

____ Yes ——→ Who? (RECORD relationship) _____

____ No

THE NEXT QUESTIONS ARE ABOUT YOUR OPINIONS. I AM GOING TO READ TWO STATEMENTS AND I WANT YOU TO TELL ME WHICH STATEMENT YOU PREFER. THERE ARE NO RIGHT OR WRONG ANSWERS TO THESE QUESTIONS. I JUST WANT YOUR OPINION.

26. Do you feel that people who watch what they eat and take care of themselves stay healthier than those who do not, OR do you think that good health is more a matter of good luck?

____ Those who watch stay healthier
____ Health more a matter of luck
____ Both ways; both are true
____ Don't know, no answer

27. Do you think it is possible for people to plan how many children they will have, OR are there too many things that can happen to mess up those kinds of plans?

____ Possible to plan children
____ Too many things mess up plans
____ Both ways; both are true
____ Don't know, no answer

28. Do you feel that people will die when it is their time and there is not much that can be done about it, OR that by taking good care of their health people can generally live longer?

____ Die when time
____ Take good care and prolong
____ Both ways; both are true
____ Don't know, no answer

29. Do you think that it is worthwhile for people to get checkups when they are well, OR that nothing much can be done to prevent most illnesses?

____ Checkups worthwhile
____ Nothing much prevents illness
____ Both ways; both are true
____ Don't know, no answer

NOW, LET ME ASK YOU SOME QUESTIONS ABOUT YOU AND YOUR FAMILY.

30. How old are you? _____

31. What is your marital status?

____ Single
____ Married
____ Separated
____ Divorced
____ Widowed

32. How many grades in school have you completed? _____

33. Are you in school now?

____ Yes

____ No

34. Do you work part-time?

____ No

____ Yes ⟶ What kind of work do you do? _____

How long have you been working at this job? _____

35. Is there anything else about these questions that you want us to tell the people in the Welfare Department or at the clinic? Your name will not be mentioned. (RECORD VERBATIM.)

_____

_____

_____

_____

_____

_____

_____

_____

THANK YOU.

Chapter III

CASE MONITORING

Test Objectives

There were no new test objectives in case monitoring in this report period. Case monitoring was in a continuum from the methods and techniques practiced in the preceding phase (3)(See Schema 2 - Chapter I, this report).

Schema

Case Monitoring Activities
July 1977 - June 1978

Time	Project Phase	SECTORS A	B	C	D
Jul.	IV	Combined Case Finder/Monitor PWW I Same Technique*	Combined Case Finder/ Monitor (CSA III) Same Technique*	Continue Separate (Full-Time) Case Monitor (WST II) Same Technique*	Continue On-Going Combined Case Finder/ Monitor (PWW I) Same Technique** (Vertically)
Aug.	"				
Sept.	"				
Oct.	"				
Nov.	"				
Dec.	"				
Jan.	"				
Feb.	"				
Mar.	"				
Apr.	"				
May	"				
June	"	Terminate	Terminate	Terminate	Terminate Data Input Only

*Primarily personal contact through in-home/face-to-face contact

**Primarily letter, sequential telephone call (if letter is unsuccessful), sequential in-home/face-to-face contact (if letter and telephone contact unsuccessful).

Case Monitoring Work Load

The work load that has been generated in the project area for follow-up is as follows:

Case Monitoring Work Load by Sector in Three Periods of Time

Number of Children Screened (All Ages)					Number of Health Problems to Resolve (All Ages)				Number of Children with Immunizations Incomplete (Under Age 6 Only)				Number of Children With Dental First Appointment to Consumate			
Sector	Feb. Dec. '76	Jan. Jun. '77	Jul. Dec. '77	Total	Feb. Dec. '76	Jan. Jun. '77	Jul. Dec. '77	Total	Feb. Dec. '76	Jan. Jun. '77	Jul. Dec. '77	Total	Feb. Dec. '76	Jan. Jun. '77	Jul. Dec. '77	Total
A	463	369	276	1108	55	39	47	141	54	32	38	124	UTILIZES 45% OF CASE MONITORING AVAILABLE EFFORT**			
B	371	260	383	1014	10	11	46	67	42	17	69	128				
C	599	470	514	1683	87	54	109	250	54	34	46	134				
D	527	271	148	946	72	16	14	102	NO DATA*							
Total				4751				560								

The work load generated by the screening volume is in all aspects remarkably low, i.e.,

a. Health Problems

Health problem referrals are identified in only 11.8% of the total screens (560 problems out of 4,751 screens). This is 2.4 times less than the overall State EPSDT problem referral rate (28.4%). In the last time period of July-December '77 the problem referral rate from screening in Sectors A, B, and D (City of Dallas Health Department Screening) was 13.3% and from Sector C (Project Screening team), 21.2%.***

b. Immunization Incompletions

A final in-depth analysis of the immunization data using a 10 percent sample (240) randomly selected immunization sheets out of the 2,398 immunization sheets from children in the file over the two years of the

*The "ongoing" DPW case workers do not monitor incomplete immunizations.

**Numbers are not available because of the separateness of the dental program. (See following narrative for more detailed explanation).

***Sector A,B,D (Jul. '77-Dec.'77) 107 ÷ 807 = 13.3%
Sector C (Ju. '77-Dec.'77) 109 ÷ 514 = 21.2%

project indicate that 44 percent of the children required further follow-up for immunizations at the completion of the screen. This would represent a potential work load for immunization follow-up in children under six that is approximately two to three times greater than health problem follow-up depending upon the rate of health problems found.*

Distribution of Case Monitoring Work Effort

Special sample studies of worker time commitments, both on-going (Sector D) and project (Sectors A,B, and C), indicate that approximately 45% of the total time spent in case monitoring is committed to follow-up to achieve a successful "kept appointment" for a first dental visit for examination and limited treatment.**

The Texas Title XIX dental program for children is unique among the states in that it is separate from the EPSDT program. This delineation includes overall program management and operation, forms, forms flow, budgeting, evaluations, etc. In this configuration of separateness, the Dallas project was not proposed to include the dental program. Consequently, it was not designed to collect data and execute evaluation of the interrelated components of the Texas Title XIX dental program. Notwithstanding, as the eligible Title XIX population (EPSDT eligibles) was divided in the project area between the on-going program and the project, the project EPSDT workers were required to execute case finding and follow-up for both the Title XIX dental program and the EPSDT program to the same degree as the ongoing workers. As previously indicated, approximately 30 percent of case finding activities and approximately 45 percent of the case monitoring activities are committed to the dental program. This information is important for an understanding of the division of full-time equivalents to various functions and developing associated program costs.

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*This statement does not include the impact of dental follow-up.

**A "case monitoring" work load distribution including dental and immunizations might be expected to pattern after that of the State of Michigan (in the two-step mode) which reports[1] the following sub categorizations by age for an overall problem referral rate of 58 percent.

	Total	0-5	over 6
Health Problems	50%	53%	48%
Dental Problems	26%	13%	36%
Immunization (Problems)	24%	34%	16%
	100%	100%	100%

[1]Michigan Annual Report 1976(EPSDT) Michigan Department of Public Health Social Services.

Evaluation of Variables

Health Problem Monitoring

Antecedent

The primary objectives of case monitoring in this project were reported upon in the reports covering Phases 2 and 3 and are included in the Summary section of this report.

Discussion and Evaluation

In this final evaluation an additional consideration is offered regarding the costs and prioritization of case monitoring.

The Phase 3 report indicates that the introduction of a system (and staff) specifically committed to case monitoring of problems found in screening generally produced "show for treatment" rates in the range of 80-90 percent. This finding was consistent with findings from the Nine State Survey* of "Shows for Treatment." In the case of Dallas, which, in the pre-test phase (as most of Texas) had already designated responsibility for case monitoring, (though staff and a back-up system were yet to be developed), this represented an increase in "shows for treatment" from 64 percent to 85 percent; an improvement of 33 percent. State programs less advanced in development of a case monitoring subsystem to EPSDT than the Texas (Dallas) program in the pre-test phase, have a potential for higher rates of improvement. On the other hand, the state with the poorest performance in the Nine State study, and in which no designated responsibility for case monitoring had been accomplished or system established, had a show for treatment rate of approximately 55 percent when those problems identified at the screening site were actually physically "tracked" to a treatment provider. This state also had the highest percentage of cases that simply were not documentable or trackable (38 percent). It must be presumed that some percentage of this latter group reached treatment, therefore, it seems safe to speculate that the actual bottom range of shows for treatment irrespective of the maturity of development of a case monitoring system may be in the rage of 50-60 percent. This base range is reinforced by the original study of shows for treatment during the start-up phase of the EPSDT program in 1973-1974 when the finding then in eight states surveyed was 46.1 percent,** and a subsequent survey conducted by the Congress covering operations in 1974 and 1975 where nine states provided data in a survey of all 50 that led to the conclusion that 60.4 percent of the children with

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*Review of Show for Treatment - Nine State Survey, HSRI - March 31, 1977

**Information Memorandum, MSA-IM-74-11 Medical Service Administration, Social Rehabilitation Service, DHEW, February 21, 1974.

problems found in screening reached treatment.*

These data suggest that once a mother is advised that her child has a health problem (found in screening), in the normal course of events, approximately 50-55 percent of them will take their child to a treatment provider without further follow-up. The maximum attainable show for treatment rate as indicated by several of the HCFA demonstration projects and the Nine State Survey (Review of Show for Treatment) appears to be in the range of 88-93 percent rather than 100 percent for states in the "one step" mode, and 78-82 percent for states in the "two step" mode. A probable explanation for the inability to reach 100 percent appears to be the frequent moves of families (cannot locate) and repeated appointment failures or overt refusals.** These latter reasons appear to come into play if the mother views the problem as inconsequential and cannot be convinced to the contrary, or the children strongly resist treatment (dental).

The mid-point of the bottom (base) range of shows for treatment is 52.5 percent, and that of the maximum range, 90.5 percent. The percent differential between the two is 38, and the maximum improvement that can be achieved is 58 percent.

Lastly, a factor producing possible variations in treatment acquisition is the pattern of follow-up that is traditional in the public health sector. Follow-up of problems, particularly if considered significant, is a traditional role of public health nurses and other public health workers. In many instances the public sector, i.e., county and city health departments, have contracts with welfare or social service agencies for the screening component of EPSDT only, with referral for treatment to the private sector and with follow-up, if designated, most often a function of the welfare or social service agency. Nevertheless, this tradition of public sector (health) follow-up continues to function to some extent and should be acknowledged to have at least some minimal beneficial impact on problem follow-up, particularly in states in the two step mode.

Normally, cost analysis for case monitoring is either predicated upon "per child screened" or "per problem found" for the total of children screened or problems found, and these demonstrated costs in this project at $12.00 per child screened, or $70.00 per health problem monitored. The

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*Department of Health, Education, and Welfare, Administration of Health Programs; Shortchanging Children: Report of the Sub-Committee, an Oversight and Investigation of the Committee on Interstate and Foreign Commerce, House of Representatives, Ninty-fourth Congress, Second Session, September 1976.

**EPSDT - A Nine State Survey and the Evaluation Reports, Phase 2,3, and 4, the Dallas project - "EPSDT in an Urban Setting"

corresponding cost to monitor a problem to "show for treatment" is approximately $106.00. If it is postulated that 52.5 percent of problems would show for treatment without a case monitoring sub system per se, then these costs may be appropriately assigned only to those problems that have to be followed up to achieve the rates in excess of 52.5 percent.

Result

If so, in a hypothetical situation, if 1,000 children were screened and 330 had problems identified (33 percent) the total cost of tracking these cases to "show for treatment" would be 330 x 1.54* = 508 problems x $106 per problem to show for treatment = $53,848. If 52 percent of these problems (508) may be presumed to "show" without follow-up, then the total costs can be assigned to the residual 48 percent or 244 problems (508 x .48 = 244). In that event, the case monitoring cost would be ($53,848 ÷ $244 = $221) $221.00 per show for treatment of those requiring case monitoring to obtain treatment.

Conclusion

This rationale, based upon data included in this report, assumes that serious problems (Healthiness Ratings of 1-3) will get to treatment by virtue of other categorical health programs, the mother's activity, or the "traditional" follow-up of the public health sector. In terms of this rationale, the whole conceptual approach to case monitoring may require review. Also contributing to this concern was the finding in the Phase 3 report that 62 percent of problems receiving treatment only required one visit to complete treatment. There are several alternatives of restricted, but prioritized, case monitoring that are suggested by the demonstration project's data. These are defined below. None of these alternatives, however, precludes the benefits of immediate explanation of a problem and information on treatment availability to a parent upon disclosure of a problem at the actual screen.

a. Limit case monitoring to follow-up of only those conditions (cases) that are rated as severe, if a condition seriousness rating scale of mild/moderate/severe is employed, and/or rated 1-4 on the healthiness rating, if a nine scale child healthiness rating is employed. This criteria would prioritize follow-up to approximately 5 percent of problems found and confirmed.

b. Limit case monitoring to follow-up of those type conditions that project and survey data indicates are normally low in "rate of show for treatment." The Nine State Survey, for example, indicated that only 57.9 percent of Mental Disorders (ICDA Codes 290-315) reached treatment, followed by 61.6 percent of Dental Problems; 68.2 percent Genitourinary Problems (ICDA Codes 588-629); 70.7 percent Musculoskeletal Problems; and 72.5 percent Nutritional Deficiencies. This criteria would prioritize follow-up to approxi-

*Conversion factor from children to problems on the basis that children with problems have an average of 1.54 problems.

mately 45 percent of problems found, 32.3 percent of which would be dental.* This approach might have greater validity if limited to just those dental cases categorized as moderate and severe (40%).** This modification would reduce the follow-up work load from 45 percent to 25.6 percent.

c. Limit case monitoring to follow-up of conditions that are potentially most disabling if unchecked, and costly to treat in later stages of development,*** i.e., mental conditions (ICDA Codes 290-315--which include psychosis, speech problems, moderate to severe developmental problems), incipient diabetes, congenital heart disease, vision and hearing problems, asthma, lead poisoning. This criteria would prioritize follow-up to approximately 30 percent of problems found.

d. Limit case monitoring at time of screening to only those children with severe conditions or low healthiness ratings (1-3) (Option"a" above) and then subsequently monitor all other cases with problems found in screening that at the end of 45 days had not "shown for treatment". This option would focus personal case monitoring on approximately 50 percent of problems found. It assumes that approximately 45 percent of problems will have "shown for treatment" on the parent's own initiative within 45 days following screening, and that the five percent severe/unhealthy children problems will have reached treatment in this same time frame. The implementation of this option, however, requires an operational management information system (forms, data processing, etc.) that provides client/provider feedback to determine those children/problems that had received, or not received, treatment within the 45 day time period indicated.

Recommendation

Contrary to existing EPSDT program direction, personal case monitoring of all problems found in screening may not be warranted by the costs involved. Cost planning (and in some instances, actual costs where fully initiated case monitoring systems are in effect) factors for case monitoring may be significantly reduced by prioritizing case monitoring and reducing the requirements for case monitors.

It is suggested, for consideration or test, that case monitoring be prioritized to focus on health conditions that are severe and children who are unhealthy, as well as on problems still untreated 45 days following screening.

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*Extrapolated from Nine State Survey data.

**The Barrio Final Report

***EPSDT; A Twenty Year Cost Benefit Analysis

Immunizations

Antecedents and Discussion

An earlier evaluation report of the project indicates a concerted effort was made to follow-up on incomplete immunizations as an effort to achieve high rates of immunization completion (current for age). This activity was limited to pre-school children (under six years of age) since Texas State law requires up to date immunizations for school registration.

Case monitors were assigned incomplete immunization sheets for follow-up in the same manner in which they were assigned problem sheets.

In the project design three levels of measurement of immunization completions were established. One was to measure those children with up-to-date immunization upon appearing for screening. The second was to measure those completing screening to ascertain the increased rate of immunization completion associated with the screening, per se, and the third was to determine those that completed immunization series subsequent to the screening as a result of case monitoring.

Case monitors were required to make at least three efforts to achieve a clinic "show" for subsequent immunizations. Transportation was provided in the same manner as if the child had a health problem.

Results

The results were most disappointing. Only three percent of children were subsequently brought "current" within four months following screening. The overall results were as follows:

Current entering Screening	45 percent	
Current exiting Screening	56 percent	(+ 11 percent)
Current subsequent to Screening	59 percent	(+ 3 percent)

Discussion

Forty-One percent of the children in the project population were "not current for age" four months subsequent to completion of screening. Both the Phase 2 and Phase 3 reports address this problem. Case monitors tend to become highly frustrated with the immunization follow-up requirement because of their extensive commitment in time and effort with poor results. They continually cite parental lack of awareness of the consequences of incompleted immunization as the major factor in these results. Case monitors find that most parents will accept the necessary immunizations while present at a health care delivery activity for some other purpose (screening, acute episodic, etc.), but will demur from making any "special" effort to get to a clinic, etc. solely for that purpose.

As previously indicated in earlier reports, the achievement of high levels of protection for children for school admission, or for pre-school children, will require long range preventive health education initiatives and short range aggressive outreach efforts such as maximizing immunizations at all normal encounters of children with the health care delivery systems, and assuring adequate reimbursement to providers (both public and private) or taking immunization programs to neighborhoods "at risk" through means of mobile immunization clinics, or, if the "at risk" condition is high enough, adopt the mobile immunization clinics to a block-by-block, door-to-door in-home approach in extremely high risk areas. These efforts are, however, a form of outreach/case finding rather than case management or follow-up.

Conclusion

Improvement in the rate of immunizations brought current subsequent to screening through completions of series initiated at screening, etc. does not appear to be effectively addressed through case monitoring per se.

Though several jurisdictions have identified incomplete immunizations as health "problems" for follow-up, the adoption of this procedure in a model EPSDT system may be inappropriate. It appears to be a costly and basically non-productive effort.

Effective impact on rates of immunizations current appears to be far more a front-end (case finding) rather than a back-end (case monitoring) activity.

In the voluntary context, a form of "in-home immunization" in high risk neighborhoods through mobile immunization clinics may be the effective means of achieving high levels of "current for age."

Chapter IV

COSTS

General

All guidelines, forms, instructions, etc., for collecting and reporting cost data by the project are included in the EPSDT Demonstration Model--Evaluation Handbook published by HSRI in May, 1975. The basic cost data collection individual worksheet and the instruction sheet covering its preparation are included in Appendices 2 and 4 to Chapter V, this report, for reference.

The system devised was, to a great extent, a result of the Institute's experience in establishing cost data systems for the "old" demonstration projects (i.e., Cuba, New Mexico; Contra Costa, California; Washington, D.C.; San Antonio, Texas).

The cost elements of analysis, e.g., average cost of shows for screen, average cost of problems completed, etc., are dependent upon:

(1) accurate reporting of project employee hours by subsystem or designated major activity;
(2) accurate reporting of total costs per month chargeable to specifically designated accounts.

Direct costs, such as salaries, screens, treatments, etc., are relatively easily identified with subsystems (case finding, screening, diagnosis, treatment and case monitoring) for specific components of time (or sector).

Indirect costs, such as rent, utilities, maintenance, depreciation and administrative support (e.g., recruiting, classification, etc.) are generally not as easily identified with a subsystem. To overcome some of these difficulties, the HSRI cost system prescribes the charging of indirect costs to subsystems or major activities, based upon the percent of personnel hours committed to each subsystem.

1. Overall Costs

(See following page for Project Operational Costs Chart)

a. Total Project Operational Costs (excludes project overhead/ management, etc.) by Major Funding Categories

Period	Average FTE's	Hours Worked	Direct Costs			Indirect Costs	Total Costs
			Personnel	Travel	Screening		
Jul.'76-Dec.'76	10.45	9,533	$60,689	$2,208	-*	$ 5,309	$68,206
Jan.'77-Jun.'77	11.98	11,407	70,979	2,953	$7,588	5,431	86,951
Jul.'77-Dec.'77	9.81	8,274	53.740	1,272	10,032**	12,278***	77,322

b. (1) Total Unadjusted Operational Costs and Percentages by Functional Category

Period	Total Costs	Case Finding	Case Monitoring	Screening	Orient. & Training	Administration & Management
Jul.'76-Dec.'76	$68,206 (100%)	$28,532 (42%)	$23,826 (35%)	0**** 0	$4,059 (6%)	$11,789 (17%)
Jan.'77-Jun.'77	86,951 (100%)	31,091 (36%)	22,009 (25%)	$18,868 (22%)	3,201 (4%)	11,782 (14%)
Jul.'77-Dec.'77	77,322 (100%)	40,137 (52%)	25,137 (32%)	10,032 (13%)	1,218 (2%)	798 (1%)

Discussion

Since the functions of case finding and case monitoring are personnel intensive, there is a very positive relationship between dollars and personnel time committed to the various functions. Additionally, to appropriately arrive at unit type costs such as "cost per family contact", "cost per kept appointment", etc., it is necessary that all appropriate operational costs be charged to the operational functions of the project, i.e., case finding, case monitoring,

*The project was not involved in executing screening during this period.

**Direct Screening Costs fully inclusive

***Includes rent, phone, supplies, security, depreciated equipment, client transportation costs. (See Appendix A, this chapter for details pertaining to client transportation costs).

****The project was not involved in executing screening during this period.

and screening. As is obvious from Tables a and b (1) above, all indirect and direct cost chargeable to the operational component of the project are appropriately reflected. Time sheets of operational workers, supervisors, and operational support personnel, however, reflect separately "orientation and training" and "administrative and management" activity (Table b) that still needs to be charged to the operational functions to develop full unit costs that would be comparable with other programs or projects unit costs.

Accordingly, $2,016 operational dollars will be sub-allocated to the operational functions in the same approximate proportions as they otherwise occur, i.e., 54% to case finding, 33% to case monitoring and 13% to screening.

b (2) Total Adjusted Costs and Percentages by Functional Category

Period	Total Costs	Case Finding Costs	Case Monitoring Costs	Screening Costs	Project Overhead Costs*
Jan.-Jun.'77	$86,951 (100%)	$32,811 (38%)	$23,249 (27%)	$19,908 (23%)	$10,983 (13%)
Jul.-Dec.'77	77,322 (100%)	41,481 (54%)	25,809 (33%)	10,032 (13%)	0

2. Case Finding Costs ($41,481)

a. Case Finding Costs per Family Contact by Sector and Time Period

	No. Family Contacts** SECTORS				Case Finding Costs SECTORS				Cost Per Family Contact SECTORS			
Period	A	B	C	Total	A	B	C	Total	A	B	C	Total
Jan.-Jun.'77	138	208	214	560	$11,812	$9,515	$11,484	$32,811	$85.59	$45.75	$53.66	$58.59
Jul.-Dec.'77	72	210	225	508	14,138	14,355	12,988	41,481	196.36	68.36	57.47	81.66

b. Case Finding Costs per Child Contact by Sector and Time Period

	No. Child Contacts** SECTORS				Case Finding Costs SECTORS				Costs per Child Contact SECTORS			
Period	A	B	C	Total	A	B	C	Total	A	B	C	Total
Jan.-Jun.'77	392	550	537	1,479	$11,812	$9,515	$11,484	$32,811	$30.13	$17.30	$21.39	$22.18
Jul.-Dec.'77	200	542	580	1,322	14,138	14,355	12,988	41,481	70.69	26.49	22.39	31.38

*Orientation and training, administration and management unique to a project conducting research. No such category (or $0) for July-Dec.

**From Family Contact Records dated in the periods indicated.

c. (1) Case Finding Costs per Kept Appointment (Show for Screen) for Sectors A,B, and C and Time Period

Period	Number Kept Appointments* SECTORS A	B	C	Total	Case Finding Costs SECTORS A	B	C	Total	Costs Per Kept Appointments SECTORS A	B	C	Total
Jan.-Jun.'77	369	260	470	1,099	$11,812	$9,515	$11,484	$32,811	$32.01	$36.60	$24.42	$29.86
Jul.-Dec. '77	280	397	517	1,194	14,138	14,355	12,988	41,481	50.49	36.16	25.12	34.74

(2) Case Finding Costs per Kept Appointment (Show for Screen) for Sector D (On-going)

Period	No. Kept.Appointments Sector D*	Case Finding Costs	Cost Per Kept Appoint. Sector D
Jan.-Jun. '77	271	$8,412	$31.04
Jul.-Dec. '77	152	5,758	37.88

3. Case Monitoring Costs ($25,809)

As indicated in previous reports and in Chapter III, this report, 45% of the project case monitoring effort is committed to achieving a successful "kept appointment" for a first dental visit of clients approved for the separate Title XIX dental program. Dental follow-up was not intended by the State to be an element of this project's activities, therefore, the original data input design did not include dental input.

As a consequence, it is only possible to develop case monitoring unit costs related to health problems, referrals, and immunization. In order to arrive at these costs, it then is necessary to categorize the total of case monitoring costs into a "dental component" and a "health/immunization component" and then develop the health/immunization unit costs as related only to that component as follows:

a. Case Monitoring Costs ($25,809) Distributed by Functional Category and Sector, July-December 1977

Sectors	Total Costs	Health Problem and Immunization Follow-Up Costs (55%)	Dental Follow-up Costs (45%)
A	$9,810	$5,395	$4,415
B	6,948	3,821	3,127
C	9,051	4,978	4,073
	$25,809	$14,194	$11,615

*From Screening Sheets dated in the periods indicated.

b. Case Monitoring Costs ($14,194) per Show for Treatment by Sector and Time Period (Medical conditions only).

Period	Number Shows for Treatment* SECTORS A	B	C	Total	Case Monitoring Costs SECTORS A	B	C	Total	Costs per Show for Treatment SECTORS A	B	C	Total
Feb.-Jun.'77	28	6	39	73	$3,943	$2,629	$4,381	$10,953	$140.82	$438.17**	$112.33	$150.04
Jul.-Dec.'77	30	23	81	134	5,395	3,821	4,978	14,194	179.83	166.13	61.45	105.92

c. Case Monitoring Costs ($14,194) per Problem and Immunization for Follow-Up and Completion by Sector, July-December 1977 (Medical Condition and Immunization)

Sector	No. Med. Refs.	Med. Refs. Compd.	Immun. Incomp.	Immun. Comp.	Med. Ref.& Immun. to be Comp.	Med. Ref.& Immun. Comp.	Case Mon. Costs	Case Mon. Cost Per Med. Ref.& Immun. for Comp.	Case Mon. Cost Per Comp. Med. Ref.& Immun. Comp.	Rate of Med. Ref.& Immun. Comp.	Aver. No. of Case Mon. FTE's Avail.	No. of Comp. Med. Ref. & Immun. Per. C.M. FTE
A	34	36	38	2	72	38	$5,395	74.93	141.97	53%	.75	51
B	57	38	69	9	126	47	3,821	30.33	81.30	37%	.40	117
C	113	99	46	0	159	99	4,978	31.31	50.28	67%	1.00	99
	204	173	153	11	357	184	14,194				2.15	47

d. Case Monitoring Costs per Show for Medical Treatment for Sector D (Ongoing)

Period	No. Kept Appointments (Medical Treatment)	Case Monitoring Costs	Cost per Kept Treatment Appt.
Jan.-Jun.'77	6	$3,604	$600.67***
Jul.-Dec.'77	7	5,793	827.57***

*From problem sheet file (medical conditions only)

**It should not be considered a representative cost based upon the small number of problems for follow-up.

***This should not be considered a representative cost based upon the small number of "kept appointments".

4. Screening Costs ($10,032)

a. Screening Costs per Kept Appointment (Show for Screen) for Sector C (Neighborhood Clinic Mode)

Period	No. of Kept Appointments Sector C	Screening Costs Sector C	Costs per Kept Appt. Sector C
Jan.-Jun.'77	470*	$16,476**	$35.05**
Jul.-Dec.'77	517*	10,032**	19.40**

The above "Neighborhood Clinic" screening costs are sub-categorized as follows:

(1) Personnel

Nursing	$3,956	
Clerical	670	
Volunteers	730***	
Sub Total		$5,356

(2) Direct Costs

Travel (for above personnel	1,032	
Supplies (medical)	459****	
Lab fees	971	
Doctors Consulting	650	
Training for Nursing Staff (personnel hours)	322	
Sub Total		3,434

*From screen sheet file dated January 1-June 30, 1977; July 1-December 31, 1977.

**Adjusted for depreciation of equipment (straight line-4 years) and allocation of training costs (straight line-2 years)

***Cost based on hrs. worked x minimum wage ($2.30/hr) plus 5.85% for Social Security.

****Medical Supplies cost $778 Jan.-June '77
Medical Supplies cost $139 Jul.-Dec. '77
Supplies were used over 12 months, therefore $\frac{\$778 + \$139}{2\ (6\ \text{months})} = \$459.$

(3) Indirect Costs

Overhead (Rent, phone, recruiting, office supplies, depreciated furniture)	280	
Equipment (specific to screening)	262*	
Volunteer Training	700**	
Sub Total		$ 1,242
		$ 10,032

b. Screening Costs per Kept Appointment (Show for Screen) for Sector C (In-Home Mode)

Period	No. of Kept Appointments	Screening Costs (Sector C)	Cost per Kept Appointment
Feb.-Mar.'78	20	$959.58	$47.98

The above "In-Home" screening costs are sub-categorized as follows:

A. Personnel		
Nurses	$573	
Aide	151	
B. Direct Costs		
Travel	82.08	
Supplies, Printing	1.00	
Lab Fees (20 x $2.19)	43.80	
Doctor's Consulting	28.00***	
C. Indirect Costs		
Overhead (phone, rent, security, furniture..)	52.70	
Equipment	28.00****	
TOTAL	$ 959.58	

*Straight line depreciation over 4 years

**Straight line depreciation over 2 years

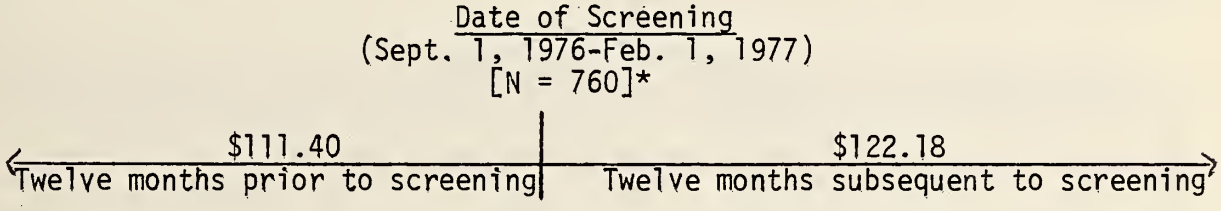
***Extremely minimal. Added on as part of contract for jobile clinic. Possible figure = $650/6 months = $110/month.
$110/100 screens = $1/screen.
20 In-Home screens x $1.40 = $28.00

****Minimal-part of equipment accounted for on mobile screen costs - assume $1.40 per screen = $28.00.

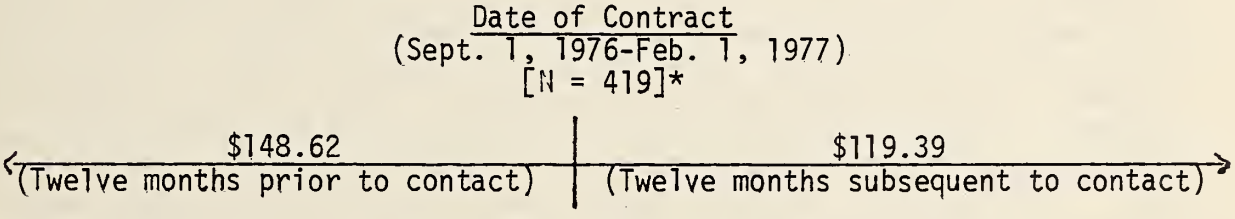
5. Diagnosis and Treatment Costs

An analysis of Medicaid costs provided by the Department of Human Resources covering the period of October 10, 1975 to February 1, 1978, for children screened in the project and children contacted and not screened, reflected the following costs for the year prior to screening and contact, and the year subsequent to screening and contact.

A. Children screened (Medicaid costs per annum without screening or dental costs)



B. Children contacted but not screened (Medicaid costs per annum without screening or dental costs)



EPSDT, per se, in this project had minimal impact on Medicaid costs when comparing these costs for the twelve months prior to screening ($111), and the twelve months following screening ($122). What real costs that do occur as a result of the program are so minimal as to be obscured by the randomly occurring costs of "sick care". This finding may be better explained by the low problem finding rate in the Dallas project area and is secondarily attributable to the large number of minor problems identified in the EPSDT program generally that are resolved in a single visit to a health care provider (62 percent, Report #3).

In a different view--of 500 children screened in the area of Dallas, only approximately 65 (13 percent, Table 19) would have health problems. These children would have a total of 72 problems (1.1 problems per child with problems, Table 19). Case monitoring would result in 80 percent of these problems or 58

*Including children both with and without other Medicaid charges for the periods indicated.

problems receiving treatment (Report #4). Sixty two (62%) percent of these problems, or 36 problems, would be resolvable in one visit to a health provider, and the balance, 22, would be resolvable in two or more visits (Report #3).

The average cost of treatment for each of these problems would be approximately $60.00*. The total cost for diagnosis and treatment of problems found and treated in 500 children screened would be approximately (58 problems x $60 per problem) $3,480 or $6.96 per child screened ($3,480 ÷ 500 children screened). If the problem finding rate were in the normally expected range of 28 percent (State of Texas overall) this would be approximately 2.15 times greater, or $14.96 per child screened.

This second view is presented to illustrate the minor impact of EPSDT related diagnosis and treatment on the totality of annual Medicaid costs. In this instance, it is estimated at approximately six percent ($6.96 ÷ $112) for children in the Dallas area, and projected more generally at thirteen percent ($14.96 ÷ 112) for children in Texas overall. It is, therefore, readily apparent as to why minor changes in randomly occurring sick costs in Medicaid largely obscure the cost of EPSDT in the overall.

If a total cost of diagnosis and treatment to include dental were developed, it could be on the following premise. Of 500 children screened, approximately 225 (45 percent)** would have dental problems. Case monitoring would result in 74 percent (Annex A-Table 2; Michigan Review of Shows for Treatment - A Nine State Survey, HSRI, March 31, 1977), or 166 receiving treatment. The average cost per child treated would be approximately $60.00 (EPSDT Diagnosis and Treatment Costs: A Five State Analysis, HSRI, August 15, 1978). The total for children treated would be (166 dental cases receiving treatment x $60 average cost per child treated for dental conditions =) $9,960. The dental costs per child screened would be in the order of $19.92 ($9,960 ÷ 500 children screened = $19.92).

Case monitoring for dental problems found would be approximately 82 percent of the costs for case monitoring health problems and immunizations or generally $8.61 per child screened (paragraph 3a, this chapter). The addition of dental diagnosis and treatment and case monitoring of dental problems would add a total of $28.53 per child screened ($19.92 + $8.61 = $28.53).

The annual Medicaid cost for the year prior to contact for children not screened being higher ($148) than for the children screened ($111) is consistent with findings of other similar studies (Cost Impact Study of the North Dakota EPSDT Program, Community Health Foundation, September 1977). The explanation for this phenomenon is that the "contacted not screened child doubtlessly

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*EPSDT Diagnosis and Treatment Costs: A Five State Analysis; HSRI, August 15, 1977.

**Table IV-2, Health Start: Final Report of the Evaluation of the Second Year Program, The Urban Institute, December 1973.

just recently had a significant sick episode (explaining the higher Medicaid costs) and the mother either overtly or covertly refused screening because of the recent exposure of her child to the health care system. It should be noted that the Medicaid costs for the year following contact ($119) are most consistent with the year before and after screen costs. It is at this point ($119) that the child would normally be recontacted for the following years periodic screen, and in this instance in which no recent significant sick episode would have occurred, it is likely that the mother would accept a screening appointment. The $119 would then represent the Medicaid costs for the year prior to screening.

APPENDIX A

(Client Transportation Costs)

Notes on Client Transportation Costs - Reported as Indirect Costs on page 101.

Project	Sector A	Sector B	Sector C	Total
Project Van* (Case finding only)	639	639	1300	$2,578
Regional Transportation** (Case finding only)	1098	1098	0	2,196
Regional Transportation***	676	676	1013	2,365
				$7,139

Client Transportation

Sector D

Reg. Transportation; Finding	$540
Reg. Transportation; Monitoring	270
	$710

Based on $5.63/ride/person

16 people per month to screen
8 people per month to treatment
(3 referred children + 3 caretakers + 2 siblings)

---

*Sectors A and B shared 1 vehicle--cost estimated at lease of $200/month + $75 gas during 6 month period.
Sector C used 1 vehicle--cost estimated on lease of $200/month + $100 gas during 6 month period.

**Average cost per ride per person = $5.63 (information from Director of Medical Services Transportation)
So - Sectors A and B - 65 people transported per month
Sector C - used own transportation or MLK transportation only.

***Average cost - $5.63/ride
Sector A and B - 40 people transported per month - consisting of 15 referred children, 15 caretakers accompanying - 10 siblings
Sector C - 30 people transported per month.

CHAPTER V

DATA ACQUISITION, MANAGEMENT, and SUPPORTING ADP SYSTEMS

Chapter Contents

Chapter V

DATA ACQUISITION, MANAGEMENT and SUPPORTING ADP SYSTEMS

General

The basic system for data collection, performance measurement, sub-system definition, testable hypotheses, sample forms, cost data input and analysis, etc. for a project to demonstrate variations in activities in an EPSDT program was established in the "EPSDT - Demonstration Model, Evaluation Handbook", developed by the Health Services Research Institute, and last printed in a revised edition on May 1, 1975. Six subsequent supplemental memorandums were written to the Handbook in 1975, dated August 4, August 28, August 28, September 8, October 21, and October 28. These provided for workload planning factors, management rosters of incomplete actions, detailed description of data elements to compute various hypotheses, etc.

Subsequent experience in the Dallas and other projects indicates that the following major modifications to the basic system should be promulgated prior to utilization in any new project or operational program.

a. Family Contact Form

1. As designed, the Family Contact Form was intended to be utilized to identify clients for which contact efforts were made and were unsuccessful (no face-to-face encounters between case finder and client) as well as for those successful face-to-face encounters (irrespective of client willingness or non-willingness to participate in the program).

De facto the form was adopted for use only if a successful encounter occurred. This action then precluded entering into the system data on "unsuccessful contacts" which nevertheless consumed case finder work effort. As a consequence, the data element "Unable to locate family" was never used as such. In retrospect, to have captured the "workload" type data committed to unsuccessful contacts not only should the entry "Unable to locate family" have been used, but generally there should have been included a data element relative to the number of efforts to contact up to a maximum of five.

2. A decision was made early in the system design that there was no need for a "linkage" in the ADP support system between the Family Contact Form (case finding sub-system) and the Screening Form (screening sub-system). This was a significant system error that did not lend itself to correction during the project. In future systems applications the family contact form should be "linked" into the continuum of the system as are the screening sheets, immunization sheets, and problem referral sheets. A result of this non-linkage is the non-reconciled

difference in numbers between the "showed for screen" from the Family Contact Form and the "screens initiated" from the Screening Form (See Table 19).

b. Immunization Sheet

The project workers involved in using the Immunization Sheet complained of its difficulty in application. The high error rate in forms submitted appears to verify this, and consideration should be given in future applications to a redesign.

The form and system prescribed in the Handbook were intended to measure those children:

(1) Current-for-age in immunizations upon entering screening
(2) Current-for-age in immunizations upon exiting screening
(3) Current-for-age in immunizations four months subsequent to screening.

These differentiated measures were apparently not fully understood within the project or the HSRI staff. Future forms redesign need to include a clarification of this delineation.

c. Management Rosters

The concept of the monthly distribution to the project of rosters reflecting incompleted actions for follow-up is most sound and effective. One modification needed is to add a roster to the 180 day incomplete problem roster. This should be a preliminary 90 day roster of incomplete problem follow-up. This roster should be a "reminder" roster, with the 180 day roster being "for explanation/or completion." Experience subsequent to writing of the Handbook indicates that 90 percent of the problems will have reached treatment within 90 days and that approximately 50 percent will have completed treatment within that time period (Table 16). There was some feeling among supervisory personnel that case monitors may, in some instances, have delayed aggressive follow-up awaiting the 180 day roster. The 90 day roster would afford supervisors and monitors an interim check point.

Data Collection Forms

Information must be gathered on the clients of EPSDT at various points of encounter in the EPSDT process in order to obtain the data necessary to describe the program. The information is obtained by having service personnel who come in direct contact with the client complete special data forms. Due to the volume of forms involved in a project the size of the one in Dallas, it would take a monumental effort with a high manpower requirement to manually compile the data from these forms in a manner that would be useful in evaluating the project. Thus,

for a project of this scope, it becomes expedient to use an automated data processing system for the storage and retrieval of data. This chapter deals with all aspects of gathering data and utilizing an automated information system to perform an analysis.

The basic components of this information system are the various data collection forms. There are four forms used to obtain data about clients in the Dallas project. These are the Family Contact Form, the Project Data EPSDT Screening Sheet, the Immunization Annex, and the EPSDT Medical Referral/Case Monitoring Sheet set. Based upon the variables proposed for testing (grant proposal) and other basic information, a list of data elements essential to the research was drawn up. From these lists and the experience gained from the use of forms in other projects, a set of forms was drafted. These forms were pre-tested at the project and then revised, using feedback from the pretest. Copies of these forms, as well as the basic screening form (TDHR-DPW Form 400 Sept. '75), may be found in Appendix 2.

Forms Distribution

Prior to printing the forms, it was necessary to conceptualize how the information requested would be obtained and then disseminated, i.e., who needed copies of forms. In order to visualize the process involved in completing the forms, a set of flow diagrams was developed (See Appendix 3). Using the diagrams as a stepping stone to more completely understand the data collection process, a set of instructions for the use of each form was drawn up. A complete set of instructions can be found in Appendix 4.

From examination of the flow diagrams, it is apparent that they all end at the point where the on-site data coordinator transmits the appropriate copies to the HSRI. The remainder of this chapter will concentrate on what takes place once the forms are received at the HSRI.

Systems Equipment (Hardware)

As mentioned in the opening paragraph, an automated data system is used to process the information. The HSRI is set up for remote entry to an IBM 370/158 computer located at San Antonio College (SAC). The computer has two megabytes of main memory running under VM/370. A brief description of the release of VM/370 implemented at SAC is found in Appendix 1. HSRI is linked to SAC via a leased phone line which supports a 3755 RJE (remote job entry) station and four 3277 display terminals (T.V.-like). Figure 1 shows the communication links between the equipment that is available to the HSRI.

In terms of input of project data, the system currently uses one of the 3277 display terminals. An operator enters data through this terminal running under the control of CICS programs. CICS is a programming language and system similar to that used the the airlines for on-line entry and retrieval. A terminal operator can enter approximately 500 documents (forms) per day. Key-punching and verification of cards is eliminated. The advantage to this is that when a name or number conflict appears or a code is out of range, the computer will not allow the form to be entered. Editing is performed "on-line."

Software Development

Programs are operational for the Family Contact, Project Screening, Immunization and Referral systems. All systems allow for entry, update, inquiry, and change. The systems are constructed in such a way as to require a minimum of effort on the part of the operator. The CICS programs only allow entries in specific fields on the screen, thus reducing the chance of error and enhancing the speed of entry. Data entered under CICS control is stored as ISAM files on 3330 disks. A detailed description of the software configuration follows Appendix 1 of this section.

Data Access and Analysis

There are two primary means by which the researcher may access the information once it is entered and stored. One is by the inquiry method, which is accomplished by entering a specific client's number, and in the screening system, one additional element of the identifying information. The record for that client is then automatically displayed on the screen. This method will retrieve only one case at a time and is generally used to pinpoint errors or to find very specific information. The other method by which the researcher accesses the data is through the pre-programmed statistical package SPSS (Statistical Package for the Social Sciences). Since SPSS works only on sequential files, a routine is executed to produce a sequential file from the on-line ISAM file. Through SPSS the researcher is able to look at either a single variable or multiple variables for the total cases on the file or any defined subset. A wide range of statistical procedures are available ranging from simple frequencies to factor analysis. It is through the use of SPSS that the rates are obtained and compared in order to test the hypotheses on which the demonstration is based.

The SPSS programs are written under the control of the CMS operating system, a versatile system allowing direct entry of program code via a display terminal, or the 3767 typewriter terminal. Once a program is written, it is transferred to the VS 1 operating system for execution. The output is received at the RJE Station printer.

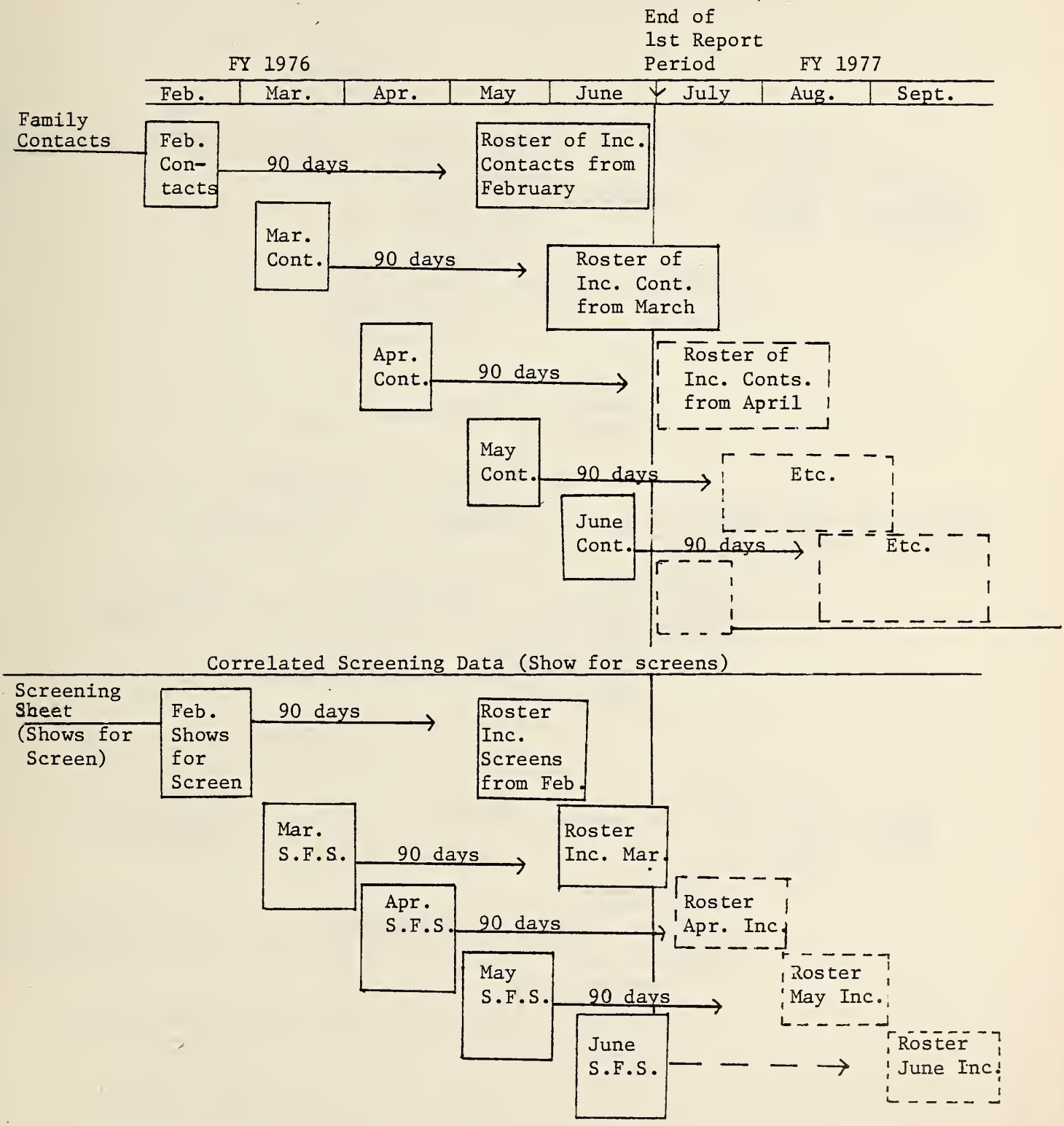
State Provided Lists of Program Eligibles

Also used in the analysis process are tapes of EPSDT eligibles sent each month from the Texas DPW data processing center. These tapes must be physically carried to SAC but the programs run against them are entered from the HSRI. The tapes are necessary in determining the penetration rates in the project. The names of "shows for screens" from the project data EPSDT screening sheet (Form T-406, see Appendix 2, following) are matched against eligibles as reflected on specific monthly tapes to determine the penetration rates at specific points in time.

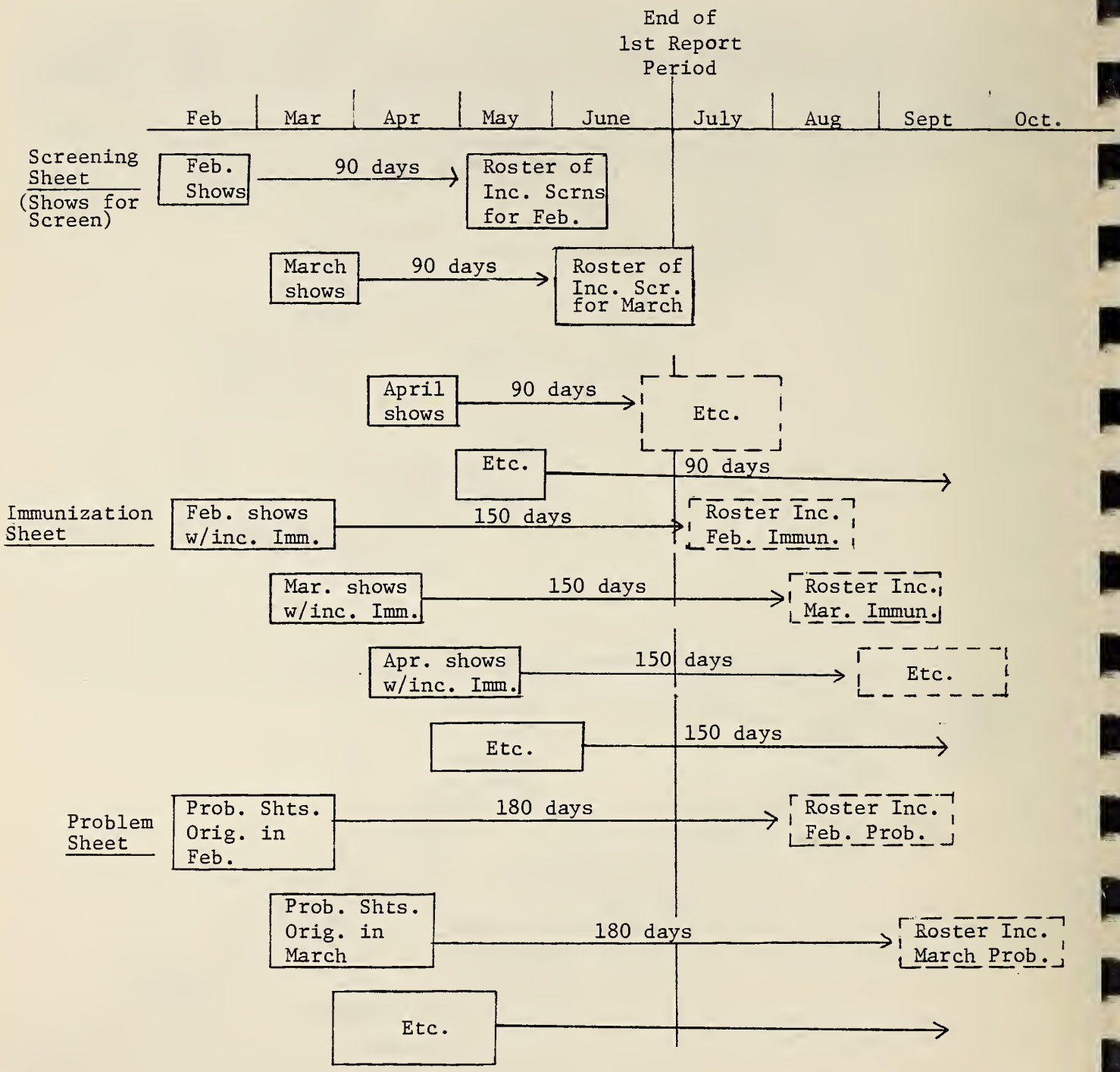
Full Cycle Data System

One other task for which the automated system is used is the production of monthly management rosters. These are lists of project data forms which have not been completed after a prescribed period of time. The time sequence schema of these various management rosters is indicated on the two following pages. The project personnel are given 21 days to complete actions indicated by the roster and to return them to the Institute. This is a tool used to avoid forms being neglected or lost over the course of the project. It has proven to be a most successful management tool.

THE CASE FINDING FOLLOW-UP DATA SYSTEM



THE CASE MONITORING FOLLOW-UP DATA SYSTEM



Appendix 1

Data Processing

A - HSRI Data Processing Hardware Configuration
B - Description of Software Configuration

Appendix 1A

HSRI Data Processing Hardware Configuration

Figure 1

HSRI DATA PROCESSING HARDWARE CONFIGURATION

Appendix 1B

Description of Software Configuration

SOFTWARE CONFIGURATION

I. Virtual Machine Facility

VM/370 release 3 is a control program that manages the resources of a single computer such that multiple computing systems appear to exist. VM/370 provides (1) virtual machines and virtual storage, (2) the ability to rune multiple operating systems concurrently, (3) a conversational time sharing system - the conversational monitor system (CMS), and (4) a remote job entry manager, the remote spooling communications sub-system (RSCS). CMS provides at a terminal, a full range of conversational capabilities: file creation and management; compilation, testing and execution of application programs. RSCS provides the remote user with the capability to automatically transfer files between: (A) VM/370 users and remote stations, (B) remote stations and other remote stations, (C) remote stations and a CMS batch virtual machine.

II. Operating Systems

A. OS/VS1 Release 5.0A
B. CMS Release 3 (Conversational Monitor System)
C. RSCS Version 1.0 (Remote Spooling Communications Subsystem)

III. Supporting Software (OS/VSI Machines)

A. Batch Monitor (Local and Remote Job Entry):
   JES/RES (Job Entry System/Remote Entry System)

B. Teleprocessing Monitor (Local and Remote):
   CICS VS/Release 1.1.1 - High Level Language Processing
   (Cobol and PL/1)

C. Student Oriented Batch (SOB) Compilers:
   1. SPASM - Single Pass Assembler
   2. WATFIV - Fortran Compiler
   3. WATBOL - AND Cobol Compiler
   4. PL/C - Student PL/1 Compiler
   5. SCRIPT - Text Processor

IV. Supporting Software (CMS)

A. Assembler
B. Basic
C. OS/VS Cobol Version 3.0
D. VS/APL (A Programming Language)
E. WATFIV Interactive Fortran
F. SPASM Single Pass Assembler
G. FORTRAN IBM's Fortran 'G' Compiler
H. PL1 IBM's Optimizing Compiler Version 1 Release 2.3
I. SORTF Fast Sort for CMS
J. CALC Desk Calculator for CMS

V. Other Supporting Software

A.	CVIS	Computerized Vocational Information System
B.	CTSS	Classroom Teachers Support System
C.	PSSP	PL/1 Scientific Subroutine Package
D.	FSSP	Fortran Scientific Subroutine Package
E.	OPTIC5	Test Scoring System, Used with OMR
F.	ASMG	Assembler 'G'
G.	SPSS	Statistical Package for the Social Sciences
H.	BMD	Biomedical Computer Programs
I.	CW3	Coursewriter III - CAI Package
J.	EASYTRIEVE	

Appendix 2

Data Collection Forms

Appendix 2A

EPSDT Family Contact Form (Project Form T-405)

State of Texas
Department of Public Welfare

Form T-405
January 1976

EPSDT FAMILY CONTACT FORM

Head of Household Medicaid No. ☐ ☐☐☐☐☐☐ ☐☐

Date of Contact ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

Casefinder ☐☐

Head of Household Name, Last ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ First ☐☐☐☐☐☐☐☐☐☐☐☐

Sector ☐☐

Address _____ ZIP _____ Phone _____

Ethnicity

Black	1 ☐
White	2 ☐
Spanish Surname	3 ☐
American Indian	4 ☐
All Other _____	
_____	5 ☐

Outcome of Contact

Willing to Participate	1 ☐
Unable to Locate Family	2 ☐
Refused to Participate	3 ☐
Screened in Another Program	4 ☐
Other _____	5 ☐

ELIGIBLES IN HOUSEHOLD

No.	Name	Age	Sex		Date for Screen	Appmt. Time	✓ if Trans. Req'd.	Screen Location
1	☐☐			1				
2	☐☐			1				
3	☐☐			1				
4	☐☐			1				
5	☐☐			1				
6	☐☐			1				
7	☐☐			1				
8	☐☐			1				

More than 8 children in family? ☐ Yes — If yes, initiate second sheet and staple together.

Name of Casefinder _____ Head of Household _____

HSRI

Appendix 2B

Screening Sheet (TDHR-DPW Form 400)

TEXAS DEPARTMENT OF HEALTH

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM

REPORT OF MEDICAL HISTORY AND SCREENING

TDH -DPW
Form 400
Jan. 1976

RECIPIENT OF SCREENING

1. D.P.W. No.	2. Name (last, first, mi)	3. Social Security No.	4. Birthdate mo - yr	5. Sex	6. Race

7. Phone No.	8. Address (street, city, zip code)	9. County

PARENT, GUARDIAN, RECIPIENT PAYEE

10. Name (last, first, mi)	11. I request my child (I) have a health screening Signature	12. Request Date

STATE EMPLOYEE OR REPRESENTATIVE

13. Signature-state employee or representative	14. Date	15. DPW Region No.	16. Unit No.	17. Mail Code	18. Phone and Ext.

19. Family Physician	20. Remarks

It should be understood that this is an initial medical screening and not a diagnostic procedure.

ITEM	NO	YES	COMMENTS
100. Premature			
101. Birth Defects			
102. Birth Injury			
103. Medical Treatment			
104. Hospitalization			
105. Tremors			
106. Difficulty in Sleeping			
107. Trouble Making Friends			
108. Bed Wetting			
109. Swelling of Nodes			
110. Swelling of Joints			
111. Skin Trouble			
112. Severe Headaches			
113. Hay Fever			
114. Dizzy Spells			
115. Frequent Colds			
116. Frequent Cough			
117. Bloody Sputum			
118. Eye Infections			
119. Vision Problems			
120. Frequent Ear Trouble			
121. Hearing Impairment			
122. Frequent Nose Bleeds			
123. Frequent Sore Throats			
124. Chest Pains			
125. Short of Breath			
126. Abdominal Pain			
127. Diarrhea			
128. Constipation			
129. Worms			
130. Vaginal Discharge			
131. Urethral Discharge			
132. Painful Urination			
133. Venereal Disease			
134. Allergies			
135. Menstrual Abnormality			
FAMILY HISTORY			
136. Diabetes			
137. Cardiovascular Disease			
138. Kidney Disease			
139. Cancer or Leukemia			
140. Mental Retardation			
141. Tuberculosis			

TDH -DPW
Form 400
Page 2
Jan. 1976

Patient's Name: _____ DPW Recipient No. ☐ ☐☐☐☐☐☐ ☐☐

IMMUNIZATION OR BOOSTER STATUS

	INCOMP.	COMP.	
142. Diphtheria			
143. Tetanus			
144. Whooping Cough			
145. Measles			
146. Polio			
147. Rubella			
	NEG.	POS.	Not Done
148. TB Mantoux			

MENTAL HEALTH AND PHYSICAL SCREENING

700. Temperature
701. Height: In.
702. Weight: Lb.
703. Blood Pressure: /

	N	ABN	Not Done	COMMENTS
704. Mental Health Screening				
705. Vision Screening				
706. Hearing Screening				
707. Development Progress (DDST)				
708. Musculoskeletal				
709. Extremities				
710. Lymphatics				
711. Skin				
712. Head				
713. Hair				
714. Scalp				
715. Eyes				
716. Ears				
717. Nose				
718. Mouth				
719. Throat				
720. Neck				
721. Lungs				
722. Breast				
723. Heart				
724. Abdomen				
725. Hernia				
726. Genitalia				
727. Reflexes				
728. Endocrinopathies				
729. Teeth				

	NEG.	POS.	NOT TESTED	
800. Urine Sugar				
801. Urine Albumin				
802. Urine Bilirubin				
803. Urine Blood				
804. Hemoglobin				
805. Hemoglobinopathies				
806. RPR				
807. Lead				
808. PKU				

900. Refer by Item No. – Date	Comments

Provider No.

Screener's Signature:

Location:

e of Screening:

Reviewed by: M.D.

Date of Review: (Signature)

TDH –White; Physician/Other Agency-Green; DPW–Yellow; Parent–Pink; Med. Screening Site–Gold

Patient's Name: _____ DPW Recipient No. ☐ ☐☐☐☐☐☐ ☐☐

IMMUNIZATION OR BOOSTER STATUS

	INCOMP.	COMP.	
142. Diphtheria			
143. Tetanus			
144. Whooping Cough			
145. Measles			
146. Polio			
147. Rubella			
	NEG.	POS.	Not Done
148. TB Mantoux			

MENTAL HEALTH AND PHYSICAL SCREENING

700. Temperature
701. Height: In.
702. Weight: Lb.
703. Blood Pressure: /

	N	ABN	Not Done	COMMENTS
704. Mental Health Screening				
705. Vision Screening				
706. Hearing Screening				
707. Development Progress (DDST)				
708. Musculoskeletal				
709. Extremities				
710. Lymphatics				
711. Skin				
712. Head				
713. Hair				
714. Scalp				
715. Eyes				
716. Ears				
717. Nose				
718. Mouth				
719. Throat				
720. Neck				
721. Lungs				
722. Breast				
723. Heart				
724. Abdomen				
725. Hernia				
726. Genitalia				
727. Reflexes				
728. Endocrinopathies				
729. Teeth				

	NEG.	POS.	NOT TESTED	
800. Urine Sugar				
801. Urine Albumin				
802. Urine Bilirubin				
803. Urine Blood				
804. Hemoglobin				
805. Hemoglobinopathies				
806. RPR				
807. Lead				
808. PKU				

900. Refer by Item No. – Date	Comments

Provider No.

of Screening:

Screener's Signature:

Reviewed by: M.D.

Date of Review: (Signature)

Location:

TDH –White; Physician/Other Agency–Green; DPW–Yellow; Parent–Pink; Med. Screening Site–Gold

Appendix 2C

Project Data - EPSDT Screening Sheet (Project Form T-406 - Project Supplement)

State of Texas
Department of Public Welfare

Form T-406
January 1976

PROJECT DATA
EPSDT SCREENING SHEET

Medicaid No. or Client No. ☐ ☐☐☐☐☐☐ ☐☐

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

Date ☐☐ (Mo.) ☐☐ (Day) ☐☐ (Yr.)

Sex M ☐ F ☐

Birthdate ☐☐ (Mo.) ☐☐ (Day) ☐☐ (Yr.)

Ethnicity

- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other _____ 5 ☐

Screening Site

- Oak Cliff 1 ☐
- Swiss Ave. 2 ☐
- Martin L. King 3 ☐
- Lion's Club 4 ☐
- Other _____ 5 ☐

Case Monitor Code ☐☐☐

Sector ☐☐

Length of time at current address _____ Yrs. _____ Mos.

Length of time on Medicaid _____ Yrs. _____ Mos.

Transportation to Clinic

- Drove Self 1 ☐
- Free Taxi 2 ☐
- Brought by Welfare Staff 3 ☐
- Rode with Friend/Relation 4 ☐
- Walked 5 ☐
- Rode Bus/Taxi (Pub. Trans.) 6 ☐
- Rode Welfare Vehicle 7 ☐
- Other Specify _____ 8 ☐

Referred by (Check main factor)

- Newspaper ad 1 ☐
- Radio notice 2 ☐
- T.V. notice 3 ☐
- School 4 ☐
- Letter notice 5 ☐
- Walk-in 6 ☐
- Home visit (Casefinder) 7 ☐
- Phone call (Casefinder) 8 ☐
- Neighbor 9 ☐
- Other Specify _____ 10 ☐

Medical Care During Past 12 Months

No Contacts ☐

	Number of: Check-ups	Sick Visits
Private physician	☐	1 ☐
Outpatient Clinic	☐	2 ☐
Hosp. Emergency Room		3 ☐
Hosp. (inpatient) Adm.		4 ☐
Dentist	☐	5 ☐
Optometrist/Ophthal.	☐	6 ☐
School Physical	☐	7 ☐
Other _____	☐	8 ☐

Screening Sequence

- Original EPSDT ☐
- Periodic Rescreen ☐

Date for Rescreen ☐☐ (Mo.) ☐☐ (Day) ☐☐ (Yr.)

Visit Number: 1 2 3 4

State of Texas
Department of Public Welfare

Form T-406
January 1976

PROJECT DATA
EPSDT SCREENING SHEET

Medicaid No. or Client No. ☐ ☐☐☐☐☐☐ ☐☐

Date ☐☐ ☐☐ ☐☐
Mo. Day Yr.

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐ ☐
Last First M.I.

Sex M ☐ F ☐

Birthdate ☐☐ ☐☐ ☐☐
Mo. Day Yr.

Ethnicity
- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other ____________ 5 ☐

Screening Site
- Oak Cliff 1 ☐
- Swiss Ave. 2 ☐
- Martin L. King 3 ☐
- Lion's Club 4 ☐
- Other ____________ 5 ☐

Case Monitor Code ☐☐☐

Sector ☐☐

Length of time at current address ______ Yrs. ______ Mos. Length of time on Medicaid ______ Yrs. ______ Mos.

Transportation to Clinic
- Drove Self 1 ☐
- Free Taxi 2 ☐
- Brought by Welfare Staff 3 ☐
- Rode with Friend/Relation 4 ☐
- Walked 5 ☐
- Rode Bus/Taxi (Pub. Trans.) 6 ☐
- Rode Welfare Vehicle 7 ☐
- Other Specify ____________ 8 ☐

Referred by (Check main factor)
- Newspaper ad 1 ☐
- Radio notice 2 ☐
- T.V. notice 3 ☐
- School 4 ☐
- Letter notice 5 ☐
- Walk-in 6 ☐
- Home visit (Casefinder) 7 ☐
- Phone call (Casefinder) 8 ☐
- Neighbor 9 ☐
- Other Specify ____________ 10 ☐

Medical Care During Past 12 Months

No Contacts ☐

	Number of: Check-ups	Number of: Sick Visits
Private physician	☐	1 ☐
Outpatient Clinic	☐	2 ☐
Hosp. Emergency Room		3 ☐
Hosp. (inpatient) Adm.		4 ☐
Dentist	☐	5 ☐
Optometrist/Ophthal.	☐	6 ☐
School Physical	☐	7 ☐
Other ____________	☐	8 ☐

Screening Sequence
- Original EPSDT ☐
- Periodic Rescreen ☐

Date for Rescreen ☐☐ ☐☐ ☐☐
Mo. Day Yr.

Visit Number: 1 2 3 4

Healthiness Rating ☐

TESTS AND MEASUREMENTS

		Req.	Result: Normal	Result: Abn.	Retest
1	T.B. Mantoux				
2	Vision Test				
3	Hearing Test				
4	Development (DDST)				
5	Urinalysis				
6	Hemoglobin				
7	Hemoglobinopathies				
8	Lead				
9	PKU				
10	RPR				

Total Problem Sheets Initiated ☐

Staff Code of Primary Screener ☐☐☐

Screening Now Complete? Yes ☐

Reasons for inability to Complete Screen
- Family moved 1 ☐
- Family no longer eligible 2 ☐
- Refuses to make another appmt. 3 ☐
- Unable to contact after numberous efforts 4 ☐
- Repeated appmt. failures 5 ☐
- Other ____________ 6 ☐

CASE MONITOR

Appendix 2D

Immunization Annex (Project Form T-407)

tate of Texas
epartment of Public Welfare

Form T-407
January 1976

IMMUNIZATION ANNEX

Medicaid No. or Client No.

Date ___ Mo. Day Yr.

Name ___ Last ___ First ___ M.I.

Sex M ☐ F ☐

Age ___ Yrs. Mos.

Case Monitor Code ___

Sector ___

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS				
									Routinely required for child this age?	Has child had this immunization—including this visit?	Subsequent immunizations—current series (within 4 months of this visit) only.	
	2 - 4 Mos.	4 - 6 Mos.	6 - 11 Mos.	12-17 Mos.	1 1/2-5 Yrs.	6 - 13 Yrs.	14-21 Yrs.		√ If Req'd.	Enter Date Received	Date Required	Date Received
DPT #1								1				
TOPV #1								2				
DPT #2								3				
TOPV #2								4				
DPT #3								5				
TOPV #3								6				
MEASLES								7				
RUBELLA								8				
MUMPS								9				
DPT after age 18 mos. (#3 or 4)						—	—	10				
TOPV after age 18 mos. (#3 or 4)						—	—	11				
DPT after age 4 yrs. (#3, 4, or 5) (Td if given after age 6)							—	12				
TOPV after age 4 yrs. (#3, 4, or 5)								13				
Td within last 10 yrs.								14				

KEY

DPT Diptheria and tetanus toxoids combined with pertussis vaccine

TOPV Trivalent oral polio vaccine

Td Combined tetanus and diphtheria toxoid (Adult Type).

☐ DO AT THIS AGE

■ DO AT THIS AGE ONLY IF NOT DONE AT PREVIOUSLY SCHEDULED AGE

*Enter "Date Required" only for immunizations to complete a current ongoing series such as DPT or TPOV. According to the schedules on this page no such date should be later than 4 mos. of the current visit or an entry in the column "has child has his immunization?" Accordingly immunizations will be considered current only if there is an entry under "Enter Date Received" for each immunization (√) checked as required or there is an entry under "Date Received" matching any entry under "Date Required" under the overall heading "Subsequent immunizations - current series only."

SCHEDULE FOR IMMUNIZATIONS INITIATED IN INFANCY

AGE	VACCINES
2 Mos.	DPT #1, TOPV #1
4 Mos.	DPT #2, TOPV #2
6 Mos.	DPT #3, TOPV #3
2 Mos.	Measles, Rubella, Mumps
18 Mos.	DPT #4, TOPV #4
-6 Yrs.	DPT #5, TOPV #5
4-16 Yrs.	Td (continue every 10 yrs.)

SCHEDULE FOR IMMUNIATIONS INITIATED AFTER AGE ONE

TIME INTERVAL	1–5 YRS.	6 YRS. and OLDER
First visit	DPT #1- TOPV #1	Td (1st)- TOPV (1st)
1 Mo. Later	Measles, Rubella, Mumps	Measles, Rubella*, Mumps
2 Mos. Later	DPT #2- TOPV #2	Td (2nd)- TOPV (2nd)
4 Mos. Later	DPT #3- TOPV #3	–
6-12 Mos. Later	DPT #4, TOPV #4	Td (3rd)- TOPV (3rd)
At age 14-16 Yrs.	Td (every 10 yrs.)	Td (every 10 yrs.)

*Rubella Vaccine should not be given to a post-menarchal girl without physician consultation.

Appendix 2E

EPSDT Medical Referral (TDHR-DPW-Form 402)

1.

M 131451

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT

TDH-DHR
Form 402
Sept., 1978

I. TO BE COMPLETED BY DHR OR CONTRACTING AGENCY

CASE INFO. / CLIENT INFO.

2. PATIENT'S DHR NO.

3. RECIPIENT'S (PATIENT'S) NAME (LAST, FIRST, MIDDLE INITIAL)

4. BIRTHDATE

5. CASE NAME (PAYEE) (LAST, FIRST, MIDDLE INITIAL)

7. DHR WORKER/AGENCY REPRESENTATIVE

6. MAILING ADDRESS

PHONE NO.

1st LINE

2nd LINE

CITY

STATE ZIP CODE

DHR WORKER BJN & MAIL CODE

WORKER PHONE NO.

AGENCY NAME & ADDRESS (if not DHR)

8. SENT TO (PHYSICIAN'S NAME, ADDRESS, ZIP):

PHYSICIAN PHONE NO.

9. APPOINTMENT TIME

DAY

DATE

10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

1. TDH PROVIDER NO.

TDH CLINIC REPORT

DEAR DOCTOR:
THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPARTMENT OF HEALTH'S EPSDT SCREENING TEAM ON 2. SCREEN DATE:
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR PHYSICIAN FOLLOW-UP:

Form 400 Codes

4. TRANSMITTAL DATE

5. NATURE OF FOLLOW-UP:
☐ EMERGENCY ☐ URGENT ☐ ROUTINE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF HUMAN RESOURCES AND TEXAS DEPARTMENT OF HEALTH

SIGNATURE OF PARENT OF GUARDIAN

SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

TO DHR

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT?

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED ☐ CONTINUED OFFICE CARE ☐ SENT TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. DIAGNOSIS – REMARKS:

*PLEASE NOTIFY WORKER (SECTION 1, No. 7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE.
THANK YOU FOR YOUR COOPERATION.

1.

M 131451

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT

TDH-DHR
Form 402
Sept., 1978

I. TO BE COMPLETED BY DHR OR CONTRACTING AGENCY

CASE INFO.

2. PATIENT'S DHR NO.

3. RECIPIENT'S (PATIENT'S) NAME (LAST, FIRST, MIDDLE INITIAL)

4. BIRTHDATE

5. CASE NAME (PAYEE) (LAST, FIRST, MIDDLE INITIAL)

7. DHR WORKER/AGENCY REPRESENTATIVE

6. MAILING ADDRESS

1st LINE

2nd LINE

CITY

STATE ZIP CODE

PHONE NO.

DHR WORKER BJN & MAIL CODE

WORKER PHONE NO.

AGENCY NAME & ADDRESS (if not DHR)

CLIENT INFO.

8. SENT TO (PHYSICIAN'S NAME, ADDRESS, ZIP):

PHYSICIAN PHONE NO.

9. APPOINTMENT TIME

DAY

DATE

10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

1. TDH PROVIDER NO.

PROVIDER INFORMATION AND TDH CLINIC REPORT

DEAR DOCTOR:

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPARTMENT OF HEALTH'S EPSDT SCREENING TEAM ON 2. SCREEN DATE:
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR PHYSICIAN FOLLOW-UP:

Form 400 Codes

4. TRANSMITTAL DATE

5. NATURE OF FOLLOW-UP:

☐ EMERGENCY ☐ URGENT ☐ ROUTINE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF HUMAN RESOURCES AND TEXAS DEPARTMENT OF HEALTH

SIGNATURE OF PARENT OF GUARDIAN

SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DHR

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*

NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT?

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE

☐ NO FURTHER TREATMENT NEEDED ☐ CONTINUED OFFICE CARE ☐ SENT TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?

☐ YES ☐ NO (explain, if yes)

6. DIAGNOSIS – REMARKS:

*PLEASE NOTIFY WORKER (SECTION 1, No. 7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE.
THANK YOU FOR YOUR COOPERATION.

Appendix 2F

EPSDT Medical Referral (TDHR-DPW Form 402-1)

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO. / CLIENT INFO.

1. PATIENT'S DPW NO. | 2. CASE NAME (PAYEE) | 3. REFERRAL NO.

4. PATIENT'S NAME (LAST, FIRST, MIDDLE) | 5. BIRTH DATE

6. ADDRESS (STREET, CITY, STATE, ZIP) | PHONE NO.

7. DPW WORKER/AGENCY REPRESENTATIVE | DPW WORKER BJN/ AGENCY NAME & ADDRESS | WORKER PHONE NO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP): | PHYSICIAN PHONE NO.

9. APPOINTMENT TIME | DAY | DATE | 10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON

2. SCREEN DATE

AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN | SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address) ⇨

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Health Provider

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO. / CLIENT INFO.

1. PATIENT'S DPW NO. | 2. CASE NAME (PAYEE) | 3. REFERRAL NO.

4. PATIENT'S NAME (LAST, FIRST, MIDDLE) | 5. BIRTH DATE

6. ADDRESS (STREET, CITY, STATE, ZIP) | PHONE NO.

7. DPW WORKER/AGENCY REPRESENTATIVE | DPW WORKER BJN/ AGENCY NAME & ADDRESS | WORKER PHONE NO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP): | PHYSICIAN PHONE NO.

9. APPOINTMENT TIME | DAY | DATE | 10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON

2. SCREEN DATE

AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN | SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address) ⇨

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO. / CLIENT INFO.

1. PATIENT'S DPW NO. | 2. CASE NAME (PAYEE) | 3. REFERRAL NO.

4. PATIENT'S NAME (LAST, FIRST, MIDDLE) | 5. BIRTH DATE

6. ADDRESS (STREET, CITY, STATE, ZIP) | PHONE NO.

7. DPW WORKER/AGENCY REPRESENTATIVE | DPW WORKER BJN/ AGENCY NAME & ADDRESS | WORKER PHONE NO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP): | PHYSICIAN PHONE NO.

9. APPOINTMENT TIME | DAY | DATE | 10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON

2. SCREEN DATE

AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN | SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE | 2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO* NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address) ⇨

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) — REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Casemonitor → EPSDT Regional Coordinator

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO. | 2. CASE NAME (PAYEE) | 3. REFERRAL NO.

4. PATIENT'S NAME (LAST, FIRST, MIDDLE) | 5. BIRTH DATE

6. ADDRESS (STREET, CITY, STATE, ZIP) | PHONE NO.

7. DPW WORKER/AGENCY REPRESENTATIVE | DPW WORKER BJN/ AGENCY NAME & ADDRESS | WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP): | PHYSICIAN PHONE NO.

9. APPOINTMENT TIME | DAY | DATE | 10. RESCHEDULED APPOINTMENTS

1. TDHR PROVIDER NO.

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

2. SCREEN DATE

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN | SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address) ⇨

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

TDHR-DPW
Form 402-1
May 1976

EPSDT
EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
MEDICAL REFERRAL

I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO. / CLIENT INFO.

1. PATIENT'S DPW NO. | 2. CASE NAME (PAYEE) | 3. REFERRAL NO.

4. PATIENT'S NAME (LAST, FIRST, MIDDLE) | 5. BIRTH DATE

6. ADDRESS (STREET, CITY, STATE, ZIP) | PHONE NO.

7. DPW WORKER/AGENCY REPRESENTATIVE | DPW WORKER BJN/ AGENCY NAME & ADDRESS | WORKER PHONE NO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP): | PHYSICIAN PHONE NO.

9. APPOINTMENT TIME | DAY | DATE | 10. RESCHEDULED APPOINTMENTS

II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

2. SCREEN DATE

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN | SIGNATURE DATE

III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Case Record

Appendix 2G

EPSDT Case Monitoring Sheet (Project Form T-408)

State of Texas
Department of Public Welfare

Form T-408
April 1976

EPSDT CASE MONITORING SHEET

1. Patient's DPW No. ☐ ☐☐☐☐☐☐ ☐☐

2. Referral No. ☐☐☐☐☐☐

3. Case Monitor Code ☐☐☐

4. Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

5. Appointment Record

DATE	APPM'T. TIME	APPM'T. KEPT	COMMENTS

6. Narrative Summary of follow-up

_____

_____

_____

_____

_____

7. Problem Status (180 days after referral date or upon problem completion)
   a. Treatment completed, condition presumed cured or inactive after 1st visit ..... 1 ☐
   b. Treatment plan completed – now cured or inactive (follow-up contact) ..... 2 ☐
   c. Treatment terminated – maximum benefit achieved (not necessarily inactive or cured) ..... 3 ☐
   d. Still under treatment (original practitioner/clinic) ..... 4 ☐
   e. Still under treatment (referred practitioner/clinic) ..... 5 ☐

8. Method of follow-up
   Mail ..... 1 ☐
   Phone ..... 2 ☐
   Personal contact ..... 3 ☐
   Other
   Specify _____ 4 ☐

9. Reasons for inability to complete problem
   Family moved ..... 1 ☐
   Family no longer eligible ..... 2 ☐
   Refuses to make another appmt. ..... 3 ☐
   Unable to contact after numerous efforts ..... 4 ☐
   Repeated appmt. failures ..... 5 ☐
   Other
   Specify _____ 6 ☐

10. Date form completed

_____
Mo. / Day / Yr.

HSRI

11. DPW Worker Signature _____

State of Texas
Department of Public Welfare

Form T-408
April 1976

EPSDT CASE MONITORING SHEET

1. Patient's DPW No. ☐ ☐☐☐☐☐☐ ☐☐

2. Referral No. ☐☐☐☐☐☐

3. Case Monitor Code ☐☐☐

4. Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

5. Appointment Record

DATE	APPM'T. TIME	APPM'T. KEPT	COMMENTS

6. Narrative Summary of follow-up

_____

_____

_____

_____

_____

7. Problem Status (180 days after referral date or upon problem completion)

a. Treatment completed, condition presumed cured or inactive after 1st visit ..... 1☐
b. Treatment plan completed – now cured or inactive (follow-up contact) ..... 2☐
c. Treatment terminated – maximum benefit achieved (not necessarily inactive or cured) ..... 3☐
d. Still under treatment (original practitioner/clinic) ..... 4☐
e. Still under treatment (referred practitioner/clinic) ..... 5☐

8. Method of follow-up

Mail ..... 1☐
Phone ..... 2☐
Personal contact ..... 3☐
Other
Specify _____ 4☐

9. Reasons for inability to complete problem

Family moved ..... 1☐
Family no longer eligible ..... 2☐
Refuses to make another appmt. ..... 3☐
Unable to contact after numerous efforts ..... 4☐
Repeated appmt. failures ..... 5☐
Other
Specify _____ 6☐

10. Date form completed

/ /
Mo. Day Yr.

CASE MONITOR

11. DPW Worker Signature _____

Appendix 2H

EPSDT Medical Referral Supplement (Form 402-S)

Form 402-S
SEPT. 1976

1. REFERRAL NO. * M

EPSDT MEDICAL REFERRAL SUPPLEMENT

A. FOR COMPLETION BY FOLLOW-UP WORKER

2. PATIENT'S DPW NUMBER

3. RECIPIENT'S (PATIENT'S) NAME (LAST, FIRST, MIDDLE INITIAL)

B.

1. EXAMINATION DATE

2. WAS INITIAL APPOINTMENT KEPT? ☐ Yes ☐ No
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT?

3. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ Yes ☐ No

4. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED | ☐ CONTINUED OFFICE CARE | ☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ Yes ☐ No

6. DIAGNOSIS:

7. SOURCE OF INFORMATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

C.

1. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
} explain ⇨
☐ CLIENT NO LONGER ELIGIBLE ☐ CLIENT NOT LOCATABLE

D.

1. DPW WORKER/AGENCY REPRESENTATIVE NAME

WORKER BJN & MAILCODE

AGENCY NAME AND ADDRESS (if not DPW)

SIGNATURE

DATE

*MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION 1, ITEM 1.

Appendix 2I

Individual Work Sheet (Completed by project employees to develop functional cost data)

INDIVIDUAL WORK SHEET

Name of Employee: _____ Week of _____
(Monday - Sunday)

Job Title: _____ Job Title No. Code _____

Activity of Assignment _____

Major Activities	Total Hrs. Available This Week	Hours Worked Per Major Activity — Days of the Week							Total Hrs. Worked
		1	2	3	4	5	6	7	
Case-Finding									
Original Screens									
Rescreens									
Screening									
Diagnosis & Treatment									
Case-Monitoring									
Problem Completions									
Screen Completions									
Health Education									
Other Exper. Activ. Specify 1.									
2.									
3.									
Orientation/Staff Trng./Staff Conf.									
Managerial/Adminis.									
TOTAL	*								

* The total of this column will normally be 40 hours unless the individual is a part-time employee. Report below if the available hours include non-productive time, such as sick leave, vacation or a holiday. For example, if one day of leave was taken, indicate below "Includes 8 hours leave."

_____

_____

Appendix 2J

Project Summary Sheet of Cost Data (Direct, Indirect, and Title XIX)

PROJECT SUMMARY SHEET OF COST DATA (DIRECT, INDIRECT, AND TITLE XIX)

MAJOR PROJECT FUNCTIONAL ACTIVITIES

Weekly (Section I) Period covered _____ From _____ To _____

Quarterly (Sections I & II)

					CASE FINDING			SCREENING			DIAG. & TREATMENT			CASE MONITORING			HEALTH EDUC.			OTHER EXPER. ACT.			ORIENT/STAFF TRNG			MANGRL/OTHER ADM.		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
SECTION I PERSONNEL DATA	No. of fulltime equivalents, each category of Personnel	Total hours net week available for work for each category of Personnel	Ind. weekly rate of comp. per fulltime equivalents each category of Personnel	Total weekly personnel costs, each category of personnel (Col. 1xCol. 3)	Code 1 ...	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3	Code 1	Code 2	Code 3
Category of Personnel Proj. Mgmt. & Admin						Col. 5 ÷ Col. 2	Col. 4x Col. 6		Col. 8 ÷ Col. 2	Col. 4x Col. 9		Col. 11 ÷ Col. 2	Col. 4x Col. 12		Col. 14 ÷ Col. 2	Col. 4x Col. 15		Col. 17 ÷ Col. 2	Col. 4x Col. 18		Col. 20 ÷ Col. 2	Col. 4x Col. 21		Col. 23 ÷ Col. 2	Col. 4x Col. 24		Col. 26 ÷ Col. 2	Col. 4x Col. 27
1 Project Director																												
2 Admin. Asst (Cost Analyst Budget & Fiscal)																												
3 Secretary																												
4 Other (Identify)																												
Project Demonstration																												
5 Physicians																												
6 PHN's																												
7 RN's																												
8 LVN's (LPN's)																												
9 Physician Assistant																												
10 Sector Coordinator																												
11 Volunteer Coordinator																												
12 Volunteers (type function)																												
13 Case finding																												
14 Screening																												
15 Case monitoring																												
16 Administrative																												
17 Other (Identify)																												
18 Case finding Aides																												
19 Screening Aides																												
20 Case monitoring Aides																												
21 Administrative Aides																												
22 Admin. Other (Identify)																												
23 Drivers																												
24 Other (Identify)																												
TOTAL																												
SECTION II - COST DATA																												
Direct Costs by Subsystem or major activ																												
% of total hrs. avail. committed to each major activity (Row%)																												
Other Direct Costs (except Title XIX)																												
Total Direct Costs* (except Title XIX)																												
Total Indirect Costs**																												
(Distribution percentage)																												
Total Direct & Indirect Costs (except Title XIX)																												
Total XIX Costs (Based on sample data)																												
Total Direct & Ind. Costs Incl. Title XIX																												

* Categories of direct costs are: supplies & equipment, including (1) office, (2) medical equip., (3) office supplies, (4) medical supplies, (5) other office services (reproduction, etc.), (6) transportation, (7) travel

** Categories of indirect costs are: (1) gas, (2) electricity, (3) office supplies, (4) telephone, (5) transportation, (6) travel, (7) rent or depreciated building costs, (8) maintenance, (9) prorated costs of personnel employed in other activities, but committing a percent of effort to the project.

*** Code 1 - Hours worked per week, by category of personnel

**** Code 2 - Percent of total hours available for work performed in this activity, by category of personnel

***** Code 3 - Total dollars attributed to this activity, by category of personnel

All columnar headings reading "Weekly" would be understood to be "Quarterly" for the quarterly report

Appendix 3

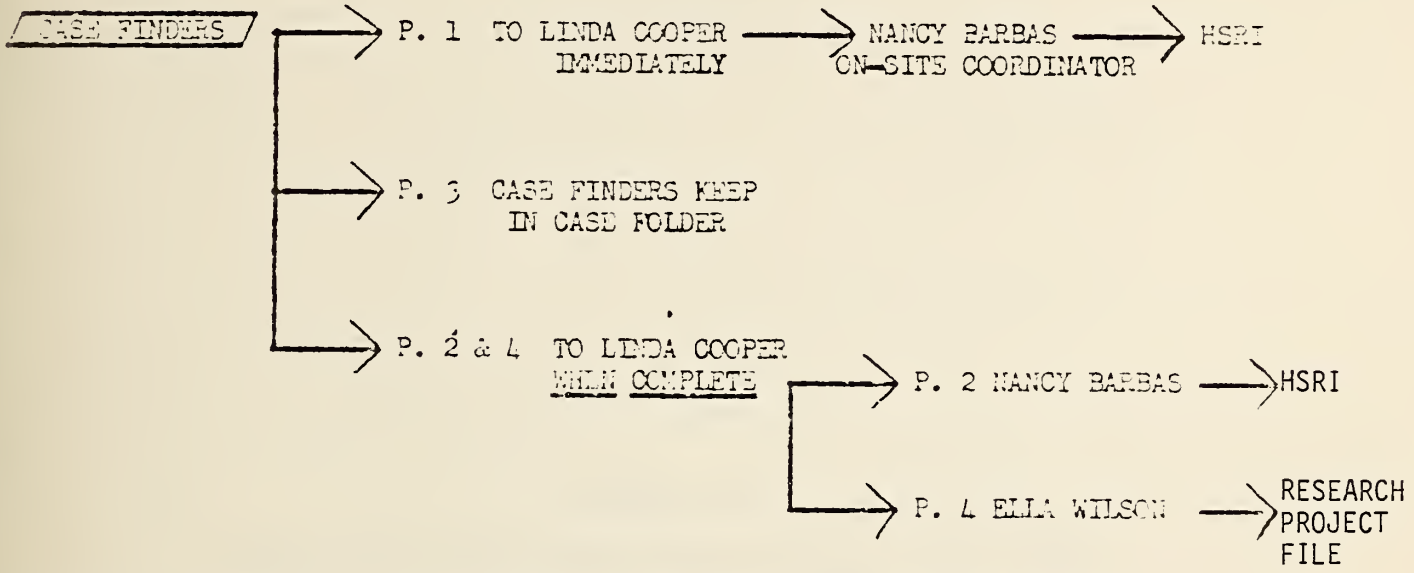
Forms Flow Sheet
Schema and Description

Appendix 3A

Family Contact Sheet

Forms Flow

Family Contact Sheet



A. The Family Contact Form is originated by the case finders for each case.

B. After the first meeting with a client when the form is originated, page 1 is turned in to the Direct Services Secretary, Linda Cooper. *Page 1 is to be turned in within 48 hours of the client contact. Pages 2, 3, and 4 are kept by the case finders in the case folders until complete.

C. The Direct Services Secretary will check page 1 against the case finders appointment list in order to insure that a form has been turned in for each scheduled client contact. On the same day in which page 1 has been received by the Secretary, the Secretary will deliver it to the On-site Coordinator. The On-site Coordinator will send page 1 to the Health Services Research Institute.

D. Pages 2, 3 and 4 are completed after the case finder has confirmed that a screening appointment has been kept or after it is confirmed the family will not keep the appointment (see instructions for filling out family contact form). After completion of pages 2, 3 and 4, pages 2 and 4 will be turned in to the Direct Services Secretary.*

E. The Direct Services Secretary will deliver page 2 to the On-site Coordinator who will send page 2 to the Health Services Research Institute. The Direct Services Secretary will deliver page 4 to the Statistical Clerk, Ella Wilson, who will file page 4 in the research project file.

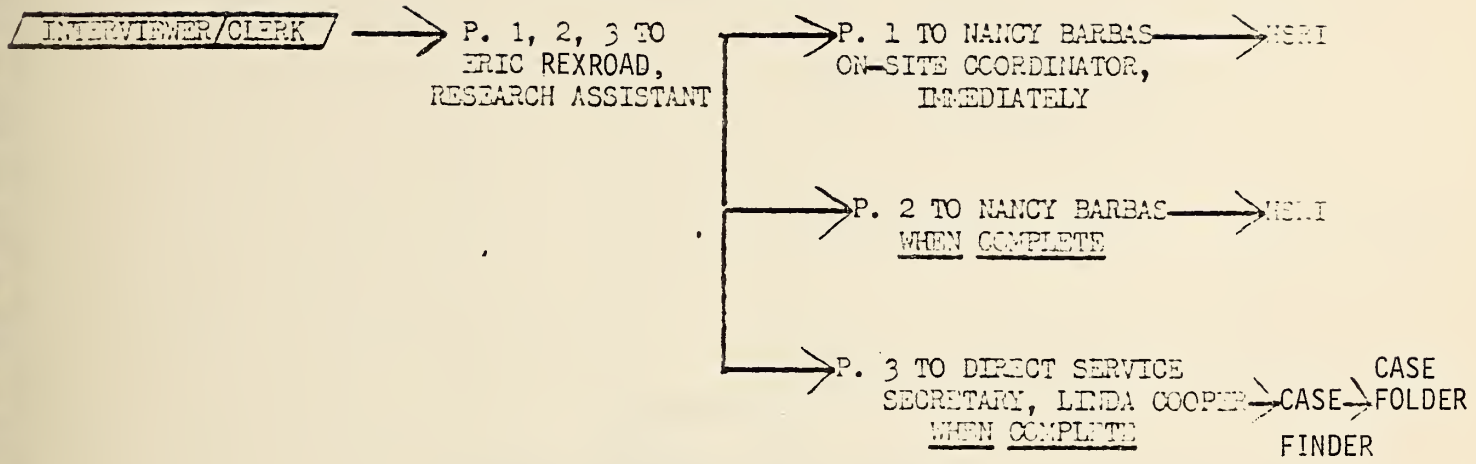
*(Special Instructions to Student Interns: Turn in pages as indicated in these instructions to LaVivian Graham, Assistant Project Director, rather than to the Direct Services Secretary).

Appendix 3B

Project Data Sheet (Screen Sheet Supplement, Form T-406)

Forms Flow

Project Data Sheet



A. The Project Data Sheet is originated at the screening site by the interviewer/clerk for each child/client who is screened and lives within the demonstration area. In order to insure that a Data Sheet is completed for each patient who shows for an appointment, the interviewer/clerk will check off form completions on a clinic appointment schedule.

B. Pages 1, 2 and 3 are to be turned in to the Research Assistant, Eric Rexroad, at the end of each clinic day or by the following day at the latest.

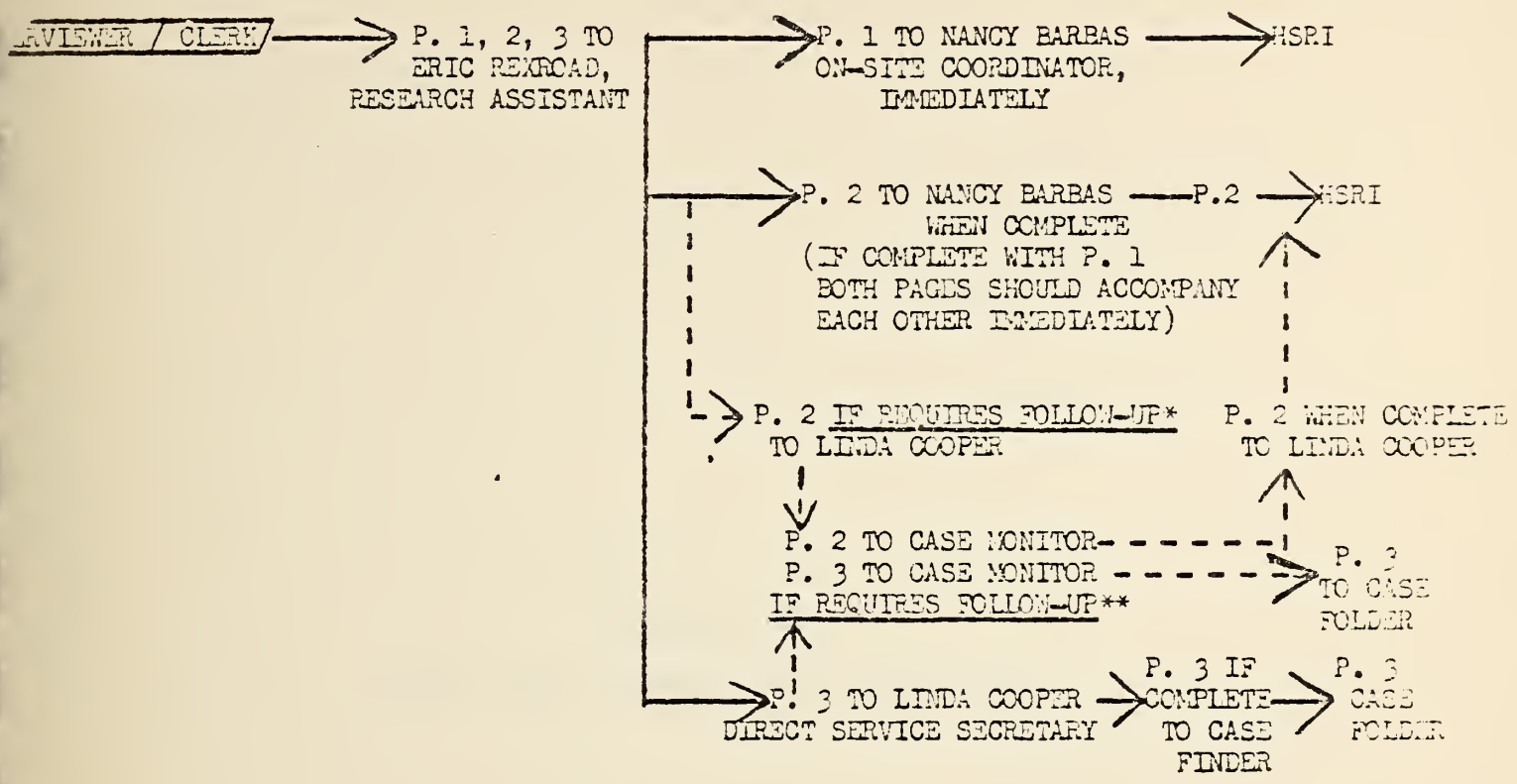
C. The Research Assistant will deliver page 1 to the On-site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute. The Research Assistant and/or statistical clerk will fill in the incompleted portion of the Data Sheet (pages 2, 3) when the test results are received by the Health Screening Team. Upon completion, page 2 will be given to the On-site Coordinator who will send it to the Health Services Institute.

D. Page 3 will be given by the Research Assistant to the Direct Services Secretary who will deliver it to the assigned case finder for filing in the case folder.

Appendix 3C

Immunization Annex (Form T-407)

Immunization Annex



The Immunization Annex is originated at the screening site by the interviewer/clerk for each child/client who is screened and lives within the demonstration area.(Originate with Project Data Sheet).

Pages 1, 2, and 3 are to be turned in to the Research Assistant, Eric Rexroad, at the end of each clinic day or by the following day at the latest. (Should accompany Project Data Sheet).

The Research Assistant will deliver page 1 to the On-site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute.

If no follow-up is necessary and the Immunization Annex is complete, page 2 will be delivered to the On-site Coordinator with page 1, who will send it to HSRI.

If no follow-up is necessary, the Research Assistant will deliver page 3 to the Direct Services Secretary within 24 hours of receiving it. The Secretary will deliver it to the appropriate case finder who will file it in the case folder.

If follow-up is necessary, page 2 will be delivered to the Direct Services Secretary for assignment to the appropriate case monitor. Upon completion of the Immunization follow-up the case monitor will return page 2 to the Direct Services Secretary who will deliver it to the On-site Coordinator. Page 2 will then be sent by the Coordinator to the Health Services Research Institute.

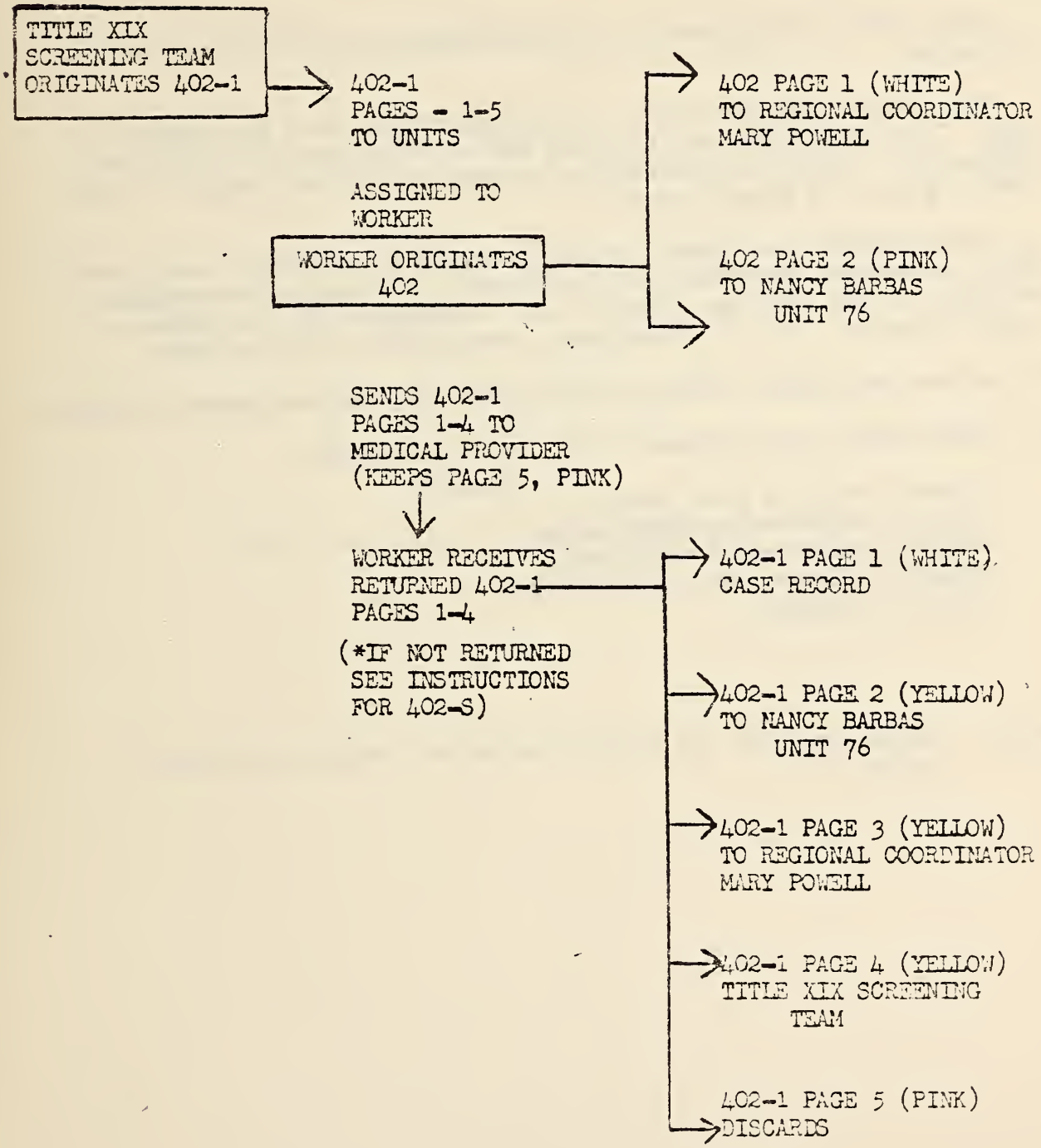
If follow-up is necessary page 3 will accompany page 2 to the Direct Services Secretary. The Secretary will deliver page 2 and page 3 to the appropriate case monitor who will complete the follow-up and then file page 3 in the case folder.

Appendix 3D

EPSDT Medical Referral - Forms 402, 402-1

EPSDT Medical Referrel - Forms 402, 402-1

Distribution Instructions



402, 402-1

1. Form 402-1 is originated by the screening team and all pages sent to the units.

2. The assigned worker receives all pages of the 402-1 and originates F402. It is very important that the 402 be filled out accurately and completely. The 402 is distributed as soon as complete, page 1 to Mary Powell, page 2 to Nancy Barbas.

3. Upon appointing a client for follow-up care, the worker sends pages 1 thru 4 to medical provider (via the client or the mail). Accompanying the 402-1 to the provider should be a.) a postage-paid, pre addressed return envelope. b.) a pre-printed cover letter to the provider.

The worker keeps page 5 (pink) of the 402-1 for case management purposes.

4. When pages 1-4 are returned they are distributed*:

- page 1 stays in case record
- page 2 delivered to Nancy Barbas
- page 3 delivered to Mary Powell
- page 4 delivered to screening team
- page 5 discarded

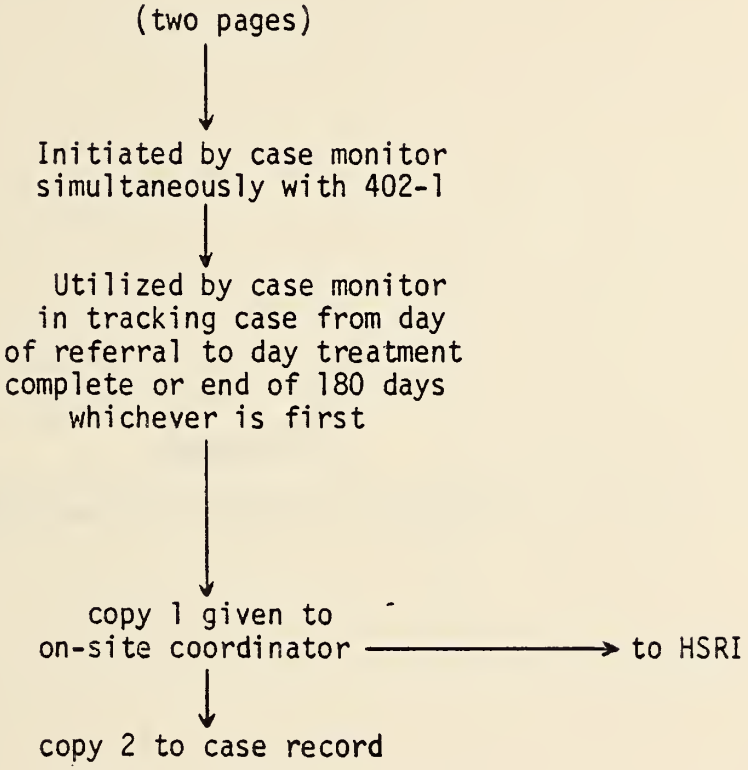
*Note: See instructions for 402-S if 402-1 not returned by Medical Provider.

Appendix 3E

EPSDT Case Monitoring Sheet (Form T-408)

CASE MONITORING SHEET FLOW

(T-408)

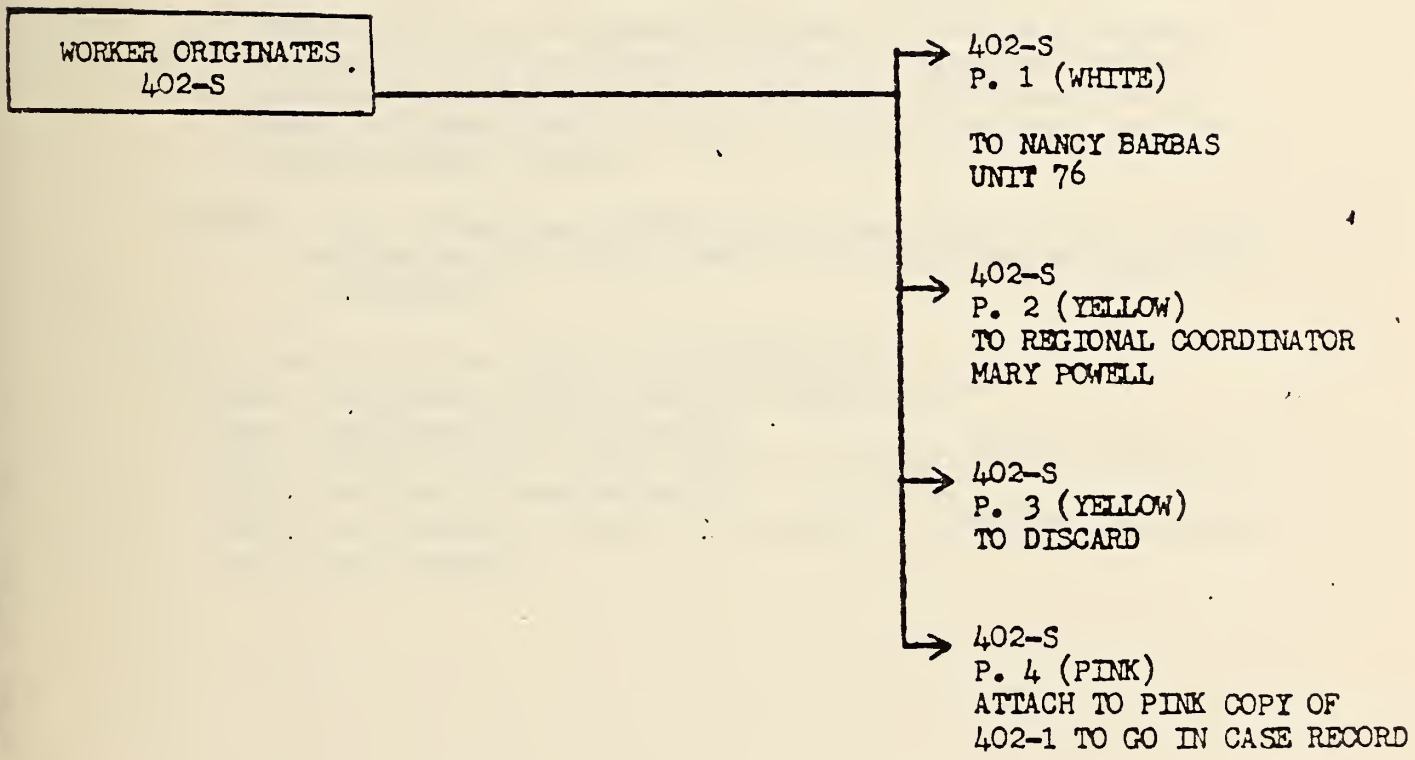


Appendix 3F

EPSDT Medical Referral (Form 402-S)

EPSDT Medical Referrel - Form 402-S

Distribution Instructions



402-S

1. Form 402-S is originated by the worker: if:

   a. Initiation of diagnosis/treatment has been received and the medical provider has not returned pages 1-4 of the 402-1 to the worker within three weeks of the scheduled appointment.

   b. Initiation of the diagnosis/treatment has not been received and the client is no longer eligible, has refused further services, is not locatable, or other circumstances that indicate a further need for worker follow to intitate the diagnosis/treatment process.

   NOTE: If the client has rescheduled an appointment, F402-S is not originated until three weeks of the rescheduled appointment if necessary.

2. Upon completing the 402-S it is distributed:
   - page 1 delivered to Nancy Barbas, EPSDT Unit 76
   - page 2 delivered to Mary Powell
   - page 3 discarded (Dr. Nancy White has requested that copies of the F402-S not be sent to her).
   - page 4 is attached to page 5, pink copy, of the 402-1 and filed in the case record.

Appendix 4

Instructions for Use of Forms

Appendix 4A

EPSDT Family Contact Form (T-405)

EPSDT Family Contact Form
(T-405)

A Family Contact Form will be initiated by the case-finding aides for each personal contact (a face to face meeting with a program-eligible head of household is a contact).

1. Head of Household Medicaid No.: Enter in the spaces provided, starting from the left, e.g.,

   Head of Household Medicaid No.

3	4	9	7	6	5	2	0	1

2. Date of Contact: The date of contact to be entered is the date of first "eye to eye" contact with the head of household for the purpose of "selling" the EPSDT program and appointing the children for screening. Fill out the boxes numerically; for example July 4, 1976 would appear as:

0	7	0	4	7	6
Mo.		Day		Year	

3. Name: Enter the last name of the head of household in the spaces provided, then the first name. It is imperative that names be spelled correctly and Medicaid numbers be entered correctly. The names in this section should be the name of the person listed on the eligibility rolls.

4. Address, Zip Code and Phone: Print the address on the line, including apartment numbers if applicable. If there is no phone, write the phone number that the head of household generally receives calls on.

5. Sector: Enter the code for "original" (1) or "periodic" (2) in the first box and the code for sector in the second box.

6. Casefinder Code: Enter your two digit code number in the boxes.

7. Ethnicity: Check the appropriate box to indicate the ethnicity of the head of household.

8. Outcome of Contact: One, and only one, of the boxes should be checked according to the outcome of the interview. If the head of household has indicated a willingness to participate in the program, efforts should be made at that point to make a specific appointment for screening for all, several, or one of the children. If the head of household consents to participate in the program, check "Willing to participate" in this section. If this box is checked, yet no dates for screen and appointment times are entered in the section under "Eligibles in household", it is assumed that the head of household did not feel free to commit to an appointment at that time.

The system provides that at least two additional efforts should be subsequently made by telephone, personal contact, etc., to schedule the children for a screening appointment. If success in appointing is not achieved by the third contact, the case-finding aide may assume that the family declines participation and the box "Refuses to make another appointment" under the section "Reasons for no show at screen" should be checked. The family will then not again be contacted (if they remain program eligible) until the next normal periodic rescreen sequence for their ages by case-finding personnel. If the family has moved or become ineligible, check "Other" and specify the reason, then check the box that applies in the section "Reasons for no show at screen" of the second page. Staple pages 1 and 2, then forward to OSDC.

9. Reasons for No Show at Screen: This section pertains to cases in which (1) an initial face to face contact has been made, but not all of the children listed have shown for screening, (2) the family has moved away, or (3) lost eligibility. The first case applies after three attempts

at scheduling screening appointments have been made, or after 90 days from date of contact. One, and only one, of the boxes should be checked. If three appointments have been scheduled for a child or children and each has not been kept, assume that the family is not interested in participating and check the box next to "Repeated appointment failures".

10. Eligibles in Household: Enter the two-digit numbers, the names (last name first), ages and sex for all program eligible children in the household. CORRECT SPELLING OF NAMES AND AGE (in years). THIS IS VERY IMPORTANT--PLEASE PRINT.

If the head of household consents to an appointment at the time of initial interview (contact) enter the date, time and location of the appointment, check whether transportation is needed and can be provided.

EXPERIENCE IN OTHER EPSDT DEMONSTRATIONS AND ON-GOING PROGRAMS INDICATES THAT SUCCESS IN HAVING EPSDT SCREENING APPOINTMENTS KEPT DEPENDS SIGNIFICANTLY ON A MINIMAL LAPSE OF TIME BETWEEN THE DATE OF CONTACT AND THE SCREENING APPOINTMENT. THE HIGHEST RATES OF SUCCESS IN SCREENING APPOINTMENTS KEPT WERE WHERE THIS PERIOD WAS LESS THAN FIVE DAYS.

If there are more than eight children in the family, check ☐ Yes at the bottom of the form, and use another sheet to continue the list of eligible children. The Medicaid number, name, date, sector, and casefinder code should be filled out on this second sheet. Staple the two sheets together.

The column "✓ if Appmt. Kept" is used to indicate that the screening appointment has been kept. This will be determined from the appointment roster that is returned to the case finder by the clinic the day after the date of appointment.

Space is provided to allow for three appointments for each child, in the event that appointments made are not kept. If the third appointment is not kept, assume the family is not interested in participating and check the box next to "Repeated Appmt. Failures" in the section "Reasons for No Show at Screen".

11. Name of Case finder: Write your name on the line.

12. Head of Household's Signature: The head of household should sign here after being presented with the opportunity to participate in the program. A signature must be obtained whether the head of household is willing to participate or not. If the head of household refuses to participate, show him/her that you have checked the box next to "Refused to Participate" and ask that he/she sign to verify that he/she has heard the advantages of the program and refuses to participate. Obtaining a signature from a willing head of household is equally important because it further strengthens the commitment to participate and to keep appointments that have been made.

Appendix 4B

Project Data Sheet (Screening Sheet Supplement T-406)

Instructions For Filling Out Project Data Sheet
(Form T - 406)

Items 1 through 9 are to be filled out at the screening site. Most of the information is obtained from the Texas DPW Screening Sheet (F400). These items should be completed before the interview.

1. Medicaid number: Copy from item #1 on F400, writing one digit per box.
2. Date: Write the screening date in the boxes, using two digits each for the month, day, and year.
3. Name: Copy the name of the person being screened from item #2 on F400, entering the last and first names and middle initial in the appropriate boxes with one letter per box.
4. Sex: Check appropriate box for sex as indicated in item #7 on F400.
5. Birthdate: Copy from item #6 on F400, one digit per box.
6. Ethnicity: Look at child's surname to determine if "Spanish Surname" is appropriate. If not, check appropriate box as indicated in item #8 on F400.
7. Screening site code: Check appropriate box. If site is other than one of the four major clinic sites, check "Other" and fill in the specific location.
8. Case monitor code: This three-digit code is broken into two parts. The first digit is an indicator of the skill level of the case monitor. The second two digits are a personal code, specifying a unique employee. Fill-in the appropriate case-monitor code according to the sector in which the client resides.

Sector	CM Code
01	111
02	221
03	331
04	000

9. Sector: The two-digit code is assigned according to the zip code and first

letter of the last name of the caretaker. The codes are as follows:

Sector	Zip Codes	First Letter of Last Name
01	75208 75203 75224 75216	A-J
02	75208 75203 75224 75216	K-Z
03	75215	A-Z
04	75223 75210	A-Z

Items 10 through 17 are questions asked of the caretaker in an interview at the screening site. Introduce yourself and explain that we are conducting a project in order to obtain information which we hope will enable us to improve the health services. Request the interviewee's help in obtaining this information, stating that you would like to ask them a few questions. Ask to see any medical and immunization records they have with them, including any received that day. Refer to these records as an aid to questions concerning medical care, health experience, and immunizations during the interview, but do not depend solely on them for a complete answer.

10. Length of time at current address: Ask: "How many years or months have you lived at your current address?" Record in the blank provided.

11. Length of time on Medicaid: Ask: "How many years or months have you currently been receiving Medicaid without a break?" If the caretaker has been on and off Medicaid, record the current consecutive length of time on Medicaid.

12. Transportation to clinic: Ask: "How did you get to the clinic today?"

"Rode bus/taxi" should be checked if the clients paid for bus, subway, or taxi fare. "Rode Welfare Vehicle" applies if the clients were transported to and from the clinic by a clinic owned vehicle. "Brought by welfare staff" should be checked if the client's caseworker or case-finder brought them. "Free taxi" will apply only to those clients in sector 01 who take advantage of the taxi transportation offered them.

13. Referred by: Ask: "What most influenced you to bring your child in for screening today?" Check appropriate box. "Home visit (casefinder)" and "Phone call (casefinder)" can apply if a caseworker or case finding aide contacted the client.

14. Medical care during past 12 months: This item identifies the place or type of medical care that the client may have had during the previous 12 months for an acute illness (sick visits) or as a preventive health measure (check-up). It is an indicator of the child's general health and the preventive health orientation of the parents. Ask: "Try to recall whether your child (you) has received any medical attention in the last year. I specifically would like to know whether he/she/you has visited:

a doctor's private office?

an outpatient clinic?

a hospital emergency room?

has been admitted into a hospital?

a dentist?

an eye doctor?

had a school physical?

any other medical provider?

(An affirmative response to any of the above categories should each be followed by:)

"How many times did you visit this health care provider? How many of these visits were made because he/she/you were feeling ill and how many visits were made as regular check-ups?" Check the box next to "No Contacts" if the child has had no medical care in the past year. Otherwise, enter the appropriate number of check-ups or sick visits in the boxes alongside each type of health care. Enter "X" in the boxes if some visits were made, but the exact number is unknown.

No Contacts ☐

	Number of:	
	Check-ups	Sick Visits
Private Physician	☐	☐
Outpatient Clinic	☐	☐
Hospital Emergency Room		☐
Hospital (Inpatient) Admissions		☐
Dentist	☐	☐
Optometrist/Ophthalmologist	☐	☐
School Physical	☐	☐
Other (Specify)_____	☐	☐

15. Screening sequence: Ask: "Is this the first time your child (you) has been to a welfare-sponsored screening program?" If the child has been screened before in any EPSDT program, including another state's, check "Periodic Rescreen". Otherwise, check "Original EPSDT".

16. Date for rescreen: In accordance with the State plan for periodic rescreens, indicate in the boxes the date on which the child will be eligible for his/her periodic rescreen.

17. Visit number: Some screening completions require more than one visit. It is necessary to ascertain the impact of multi-visits on screening and case completions. Ask: "Is this the first visit your child (you) have made to the clinic for this screening or has it been necessary for you to return to complete the screen?" In this instance, circle the number that the current visit constitutes in the ongoing screening sequence. In the initial visit, the screener would have indicated "(1)". On a subsequent second visit, using the same screening sheet, the entry would appear as "(1)(2) 3 4 ", and if, for some unusual reason, a new screening sheet was initiated for this second visit, the entry would appear as " 1 (2) 3 4 ".

Thank the interviewee for his/her time and cooperation.

Items 18 through 23 (on second sheet) are completed when the results from the lab tests are available.

18. Child's healthiness rating: Write in the same number that is circled on the scale stamped on the F400.

19. Tests and measurements: Indicate which of these tests are required at this screen by placing a check in the required column. When the results of the tests are obtained, if the result is normal place a check in the normal column; if the test result is abnormal and the State does not require a retest for abnormal conditions for that test, place a check in the abnormal column. If a retest is required because of an abnormal condition found, place a check in the retest column and leave the two columns on results blank. In this case when the results of the retest are obtained, place a check in either normal or abnormal, whichever is appropriate. When this section is completed, for each check in the required column there should be

a check in either the normal or abnormal column for that test.

20. Total problem sheets initiated: Write in the box the number of problem sheets that were initiated as a result of the screening. This information is obtained by counting the number of clinic copies of problem sheets in a child's record.

21. Staff code of primary screener: The primary screener normally is the person who completes the final review of the screening sheet, determines if any of the problems require treatment, and signs the F400 at the bottom. This three-digit staff code is similar to the case monitor code in that the first digit is an indicator of a screener's qualifications and the other two digits are the screener's personal code. The following are the screening staff codes:

Nancy White	501
Faye Smith	101
Susan Vaughn	102
Karen Alleman	103
Margaret Bushong	104
JoAnn Cook	201
Vora Bell	202
Betty Haywood	203
Carolyn Smith	204
Robbie Saunders	801
Jo Smith	802

22. Screening complete?: It is important to identify the completion of the screening sequence. The screening is complete when the physical examination and the results of all required tests have been returned, when the child's healthiness rating has been entered, and when the staff codes for the persons completing the screening sheet have been entered. Check "Yes" when complete.

23. Reasons for inability to complete screen: This section is to be completed by the case monitor. If the screen has not been completed after the client has failed to keep three consecutive appointments, or at the end of 90 days from the date of show for screen, the case monitor should check the appropriate box.

Appendix 4C

Immunization Annex (T-407)

Immunization Annex
(Form T-407)

1. Medicaid Number: Enter in the spaces provided the Medicaid number of the person being screened, e.g., | 2 | 3 | 5 | 6 | 7 | 0 | 8 | 0 | 2 |

2. Date: Enter numerically, e.g., Date | 0 | 9 | 0 | 8 | 7 | 6 |
mo. day yr.

3. Name: Print the last and first names of the person screened in the boxes provided, starting from the left in each case. If the name should contain more letters than boxes on the form, print the remainder out to the side.

4. Sex: Check the appropriate box.

5. Age: Age is included here to provide a ready reference to determine the immunization requirements for this age child generally as a base point to subsequently determine immunizations required for a particular child. Enter numerically, e.g.,

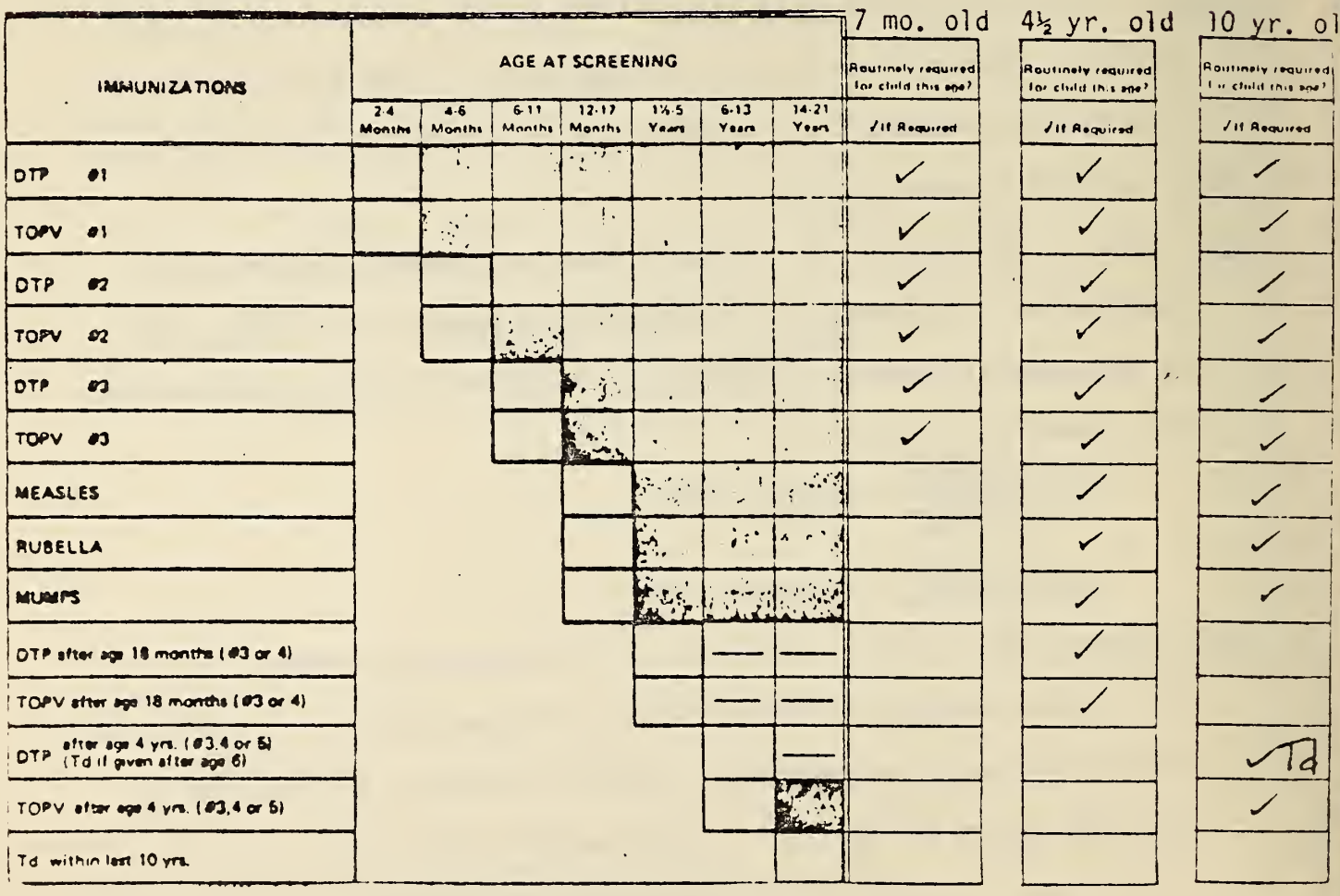
Age | 0 | 3 | 0 | 6 | (3½ years old)
yr. mo.

Age | 0 | 0 | 1 | 0 | (10 months old)

6. Case Monitor Code: Fill in the boxes with the appropriate three digit code. This item is included to assign follow-up responsibility for immunizations. The first digit is an indicator of the skill level of the case monitor. The codes are as follows: 1 - social worker (sector 01)
2 - assistant (sector 02)
3 - public health nurse (sector 03)
The next two digits are unique to the employee and will be assigned upon employment.

7. Sector: - The two digit code is assigned as specified in the instructions for the Project Data Sheet, and can be transcribed from that form.

6. Current Status - Routinely Required for Child this Age - Using the age and sex of the child being screened as the sole factors, simply use the appropriate age column on the form under the heading "Age at Screening" as the basis to check each box indicating requirements for specific immunizations, e.g., a child is male and



7. Current Status - Has Child Had this Immunization - Including Current Visit? Enter Date Received - Question the mother concerning the status of each immunization indicated as required by the previous step (paragraph 6). Immunization records kept by parents or recorded in a medical chart

can be accepted as valid. Verbal reports by parents are less valid, but can often be accepted as evidence of immunization. If the child is in school, it can be assumed that the child is up to date on immunizations since state law requires proof of immunization completeness to enter school. If exact dates of immunization are unobtainable, but the caretaker is certain that they were given, simply place a check instead of a date in the appropriate block under this column. If records are available, enter the dates of previous immunizations and then record the date of those shots given at this visit, if any. For example, for a child born November 1970, 3½ years old:

IMMUNIZATIONS	AGE AT SCREENING							Routinely required for child this one?	Has child had this immunization - including this visit?	OR Has child had this immunization - including this visit?
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1¼-5 Years	6-13 Years	14-21 Years	√If Required	Enter Date Received	Enter Date Received
DTP #1								✓	Jan. 71	1971
TOPV #1								✓	Jan. 71	1971
DTP #2								✓	Mar. 71	1971
TOPV #2								✓	Mar. 71	1971
DTP #3								✓	May 71	Aug. 7, 74*
TOPV #3								✓	May 71	Aug. 7, 74*
MEASLES								✓	Aug. 7, 74*	
RUBELLA								✓	Aug. 7, 74*	
MUMPS								✓	Aug. 7, 74*	
DTP after age 18 months (#3 or 4)						—	—	✓		
TOPV after age 18 months (#3 or 4)						—	—	✓		
DTP after age 4 yrs (#3,4 or 5) (Td if given after age 8)							—			
OPV after age 4 yrs (#3,4 or 5)										
Td within last 10 yrs.										

*Indicating those given at the current visit

8. Current Status - Subsequent Immunizations, Current Series Only (Within Four Months of Current Visit) - Date Required - This column, as well as the next one, is to be completed by the case monitor assigned to this case. Comparing the two previous steps (columns), which will have indicated the immunizations required and

those received in the past and the current visit, the action in this instance is to schedule additionally required immunizations by entering the date the next immunizations are due in the four following months; e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS			
								Routinely required for child this age?	Has child had this immunization - including this visit?	Subsequent immunizations current series (within 4 months of this visit only)	
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1¼-5 Years	6-13 Years	14-21 Years	√ If Required	Enter Date Received	Date Required	Date Received
DTP #1								✓	Jan. 71		
TOPV #1								✓	Jan. 71		
DTP #2								✓	Mar. 71		
TOPV #2								✓	Mar. 71		
DTP #3								✓	May 71		
TOPV #3								✓	May 71		
MEASLES								✓	Aug. 7, 74*		
RUBELLA								✓	Aug. 7, 74*		
MUMPS								✓	Aug. 7, 74*		
DTP after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	
TOPV after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	
DTP after age 4 yrs (#3,4 or 5) (Td if given after age 6)							—				
TOPV after age 4 yrs. (#3,4 or 5)											
Td within last 10 yrs.											

*Indicating those given at the current visit.

9. Current Status - Subsequent Immunizations - Current Series Only (Within Four Months of Current Visit): Date Received

Enter the date subsequently scheduled immunizations are received, e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

IMMUNIZATIONS	AGE AT SCREENING							CURRENT STATUS			
								Routinely required for child this age?	Has child had this immunization (including this visit)?	Subsequent immunizations current status (within 6 months of this visit only)	
	2-4 Months	4-6 Months	6-11 Months	12-17 Months	1½-5 Years	6-13 Years	14-21 Years	✓ if Required	Enter Date Received	Date Required	Date Received
DTP #1								✓	Jan. 71		
TOPV #1								✓	Jan. 71		
DTP #2								✓	Mar. 71		
TOPV #2								✓	Mar. 71		
DTP #3								✓	May 71		
TOPV #3								✓	May 71		
MEASLES								✓	Aug. 7, 74		
RUBELLA								✓	Aug. 7, 74		
MUMPS								✓	Aug. 7, 74		
DTP after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	Oct 10, 74
TOPV after age 18 months (#3 or 4)						—	—	✓		Oct 1, 74	Oct 10, 74
DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6)							—				
TOPV after age 4 yrs. (#3,4 or 5)											
Td within last 10 yrs											

When this step is completed and the subsequent immunizations received match those required, the child is now completely immunized for its age--the status is current. At the next rescreen in the following year for the child used in the above example, he will require two additional shots (DTP after age 4 and TOPV after age 4) to be considered completely immunized for his age.

Appendix 4D

EPSDT Medical Referral (Forms 402 and 402-1)

EPSDT MEDICAL REFERRAL
(Form T-402 and 402-1)

Section I - to be completed by DPW case monitors.

1. Patient's DPW case number - this is not the payee case number, but the person's number who has been screened and referred.
2. Case Name (payee) - enter the name of the person receiving grant (head of household).
3. Referral number - pre-stamped six-digit number.
4. Patient's Last, Middle, and First Name - enter the last name of the individual referred, then the first and middle names.
5. Birth Date - enter by digits the date of birth. Example: 07/08/75.
6. Address - Street/Route - City/Town - Zip - Phone number - enter client's address and phone number. Write sector code at end of address space.
7. DPW Worker/Agency Representative Name - print name of DPW case monitor, DPW BJN and case monitor code, and phone number. For example:
   Prunella Smith | 011-00-R-02-600-077-2/222 | 372-4671
8. Referred to - enter physician or appropriate medical resource's name, address, and zip code where the client is scheduled for an appointment.
9. Appointment time/day/date - enter appointment time, etc.
10. Rescheduled appointment(s) - for worker use in case record, enter new rescheduling of appointments. (See Case Monitoring Sheet for additional space.)

Section II - to be completed by screening provider.

1. TDHR provider number - enter medical screening provider number.
2. Date of screening - enter by digits (07/08/75) the date on which the client received medical screening.

3. Reason for referral - Record 400 abnormality number and explanation for medical provider. Demonstration project staff should write in major condition category code number in the space between screen date and referral date.
4. Referral date - enter by digits (07/08/75) the exact date the specified abnormality was identified and referred for diagnosis and/or treatment by the screening provider. NOTE: Except in the case of an immediate referral, the screen date and referral date will not be the same.
5. Problem History - Check one. Is the problem referred completely new to the caretaker or was it previously known and either under care or not under care.
6. Authorization for Release of Medical Information to DPW-TDHR - Appropriate person (parent or guardian) must sign and date this release. NOTE: Authorized DPW social services/personnel or the person to whom authority has been delegated should sign in the case of a foster child. The DPW worker or contracting agency representative should assist the TDHR screening provider in securing this signature.

Section III - to be completed by physician or his staff or other medical resource. NOTE: Care should be taken to include franked envelopes with the proper return address for the DPW or contracting agency worker.

1. Service or examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, he/she should enter this date and return all copies.
2. Was initial appointment kept? - Check yes or no if the client did or did

not keep the first appointment set. NOTE: This question is asterisked and refers the medical provider to the EPSDT follow-up worker for assistance if the client does not keep the first appointment.

Number of schedulings before the appointment was kept? - Enter 1 if the first appointment was kept, etc. The data generated from this item will be helpful in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.

3. Was the suspected problem confirmed at the diagnostic/treatment visit? - Check one. This data item will be utilized as a check on false positive screening findings.
4. Follow-up care - Check one. Was no further treatment, continued office treatment, or referral to another medical provider needed? Types of medical resources referrals include hospitalization referral, specialist referral, etc.
5. If follow-up care is required, do you need assistance in such areas as... - Check yes or no. This indicates the medical provider needs additional follow-up by the DPW worker to assist the client in following a treatment plan.
6. Probable diagnosis... - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

Appendix 4E

EPSDT Case Monitoring Sheet (Form T-408)

EPSDT CASE MONITORING SHEET

(Form T - 408)

1. Patient's DPW number - enter number in spaces provided.
2. Referral number - enter the referral number that is pre-stamped on the corresponding 402. It is very important that the referral numbers are correct.
3. Case monitor code - enter in boxes.
4. Name - write patient's name in boxes, one letter per box.
5. Appointment record - This space is provided to assist the case monitor in following-up on client's treatment plan. The comments section should be used to indicate outcome of appointments made.
6. Narrative summary of follow-up - This space is to be used to record information concerning treatment received. Such information will assist in completing the following question (item #7). NOTE: Either #7 or #9 will be completed, but not both.
7. Problem status - to be filled in upon problem completion or 180 days from initial date of referral. Check appropriate box. NOTE: Item b is to be checked when the problem is cured or inactive, but more than one visit was necessary to achieve this status. Item c applies if treatment plan is terminated, but the condition cannot be considered cured or inactive.
8. Method of follow-up - Check appropriate box. If various methods were used in follow-up, indicate which method resulted in the most information.
9. Reasons for inability to complete problem - If treatment cannot be completed for non-medical reasons, check appropriate item.
10. Date form completed - enter date.
11. DPW worker signature - sign.

9. Diagnosis - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

10. Source of documentation - Check the type of source of information for this form. Examples of other sources are medical receptionist, medicaid office clerk, nurse, etc.

11. Reason for non-completion of referral-treatment process - Check appropriate box and explain reason that necessitates closure of services if appropriate. Check client unlocatable or no longer eligible if appropriate. NOTE: Item #11 does not apply if items 4 through 10 were completed.

12. DPW Worker/Agency Representative - Print name of person executing the form and DPW BJN.

    Signature - Worker or representative signs Form 402-S.

    Date - Enter date information was obtained.

Appendix 4F

EPSDT Medical Referral Supplement (402-S)

EPSDT MEDICAL REFERRAL SUPPLEMENT
(Form 402 - S)

1. Patient's DPW number - enter the DPW number of the person referred from medical screening, not the payee number.
2. Patient's name - print the last, first, and middle names of the individual referred.
3. Referral number - enter by digits the exact number on the Form 402 in the case record. This item must correspond. NOTE: Complete either items 4 through 10 or item 11, based on information gathered from client and/or physician.
4. Examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, the worker should enter this date and distribute all copies appropriately.
5. Was initial appointment kept? Number of schedulings before the appointment kept? - Check appropriate box. Enter 1 if the first appointment was kept, etc. The data generated from these items will be used in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.
6. Was the suspected (referred) problem confirmed at diagnostic/treatment visit? Check appropriate box. This data item will be used as a check on false positive screening findings.
7. Follow-up care - Check one.
8. Does medical provider require assistance from worker, etc. - Check yes or no.

Appendix 4G

Entry Instructions - Individual Work Sheet

Entry Instructions - Individual Work Sheet

(Unnumbered Form-Internal Project HSRI Use)

1. Week of _____

Indicate the weekly period covered by the report - (Monday through Sunday), i.e., March 10 - 16, 1975.

2. Name of Employee

Indicate full name

3. Job Title and Job Title Number Code

The job title entered must be one of 24 contained in the category of personnel section of the Cost Data Summary Sheet (page 27) or identify with one of these 24 by the code number indicated on the Cost Data Summary Sheet. This correlation is imperative to ready conversion of individual work sheet data to summary sheet data. If there is difficulty in fitting a job title to one of these classifications, Job Title Code Number 24 may be used, which is "Other (specify) _____".

4. Activity of Assignment

The activity of assignment must be one of the eight "Major Project Functional Activities" contained in the Cost Data Summary Sheet, i.e., (1) Case-finding, (2) Screening, (3) Diagnosis and Treatment (4) Case-monitoring, (5) Health Education, (6) Other Experimental Activities, (7) Orientation/Staff Training/Staff Conferences and (8) Managerial and other Administrative Activity. This correlation is imperative to ready conversion of individual work sheet data to summary sheet data. If the "Other Experimental Activity" option is utilized to account for time, this activity (or activities) must be identified, e.g., "development of a learning disabilities screening sheet". Case monitoring activities must be broken down into two subdivisions, i.e., Problem Completion and Screen Completion. Case finding must be broken down into case finding (new cases) and rescreens. The total hours recorded in these subdivisions

should equal the entry for Case Monitoring as a whole (for each day of the week).

5. Total Hours Available this Week

The entry will be the number of hours for which paid, normally 40, unless a worker is a part-time employee (for a specified number of hours, i.e., 20 hours), or it is the number of hours actually worked by a volunteer worker.

6. Hours Worked, by Major Activity

(1) Days of the Week

The total of hours for each day will normally be eight unless one of the exception categories indicated in No. 5, above, applies. The total of daily hours will be accounted for by major activity. Any non-productive time (sick leave, vacation, compensatory time, substitute leave, etc.) should be reported in a footnote.

(2) Total Hours Worked

Based upon stipulations already identified, total hours worked should usually be the same as total available hours, except when non-productive time is involved, or where overtime is involved. If paid overtime, the total hours available should be reflected to show these as additional available hours, and then the two total columns will again coincide. If unpaid overtime, the total hours worked may exceed the total hours available but all time must be distributed by major activity. Unpaid overtime will tend to distort true costs if extensively utilized. Under such conditions a cost would have to be allocated and charged for such overtime hours.

Entry Instruction - Summary Sheet of Cost Data
(Unnumbered Form-Internal Project HSRI Use)

Summary Sheet of Cost Data

Data from individual work sheets will be transcribed weekly to Section I - Personnel Data of the Summary Sheet of Cost Data. The form (Summary Sheet of Cost Data,Chapter V-Appendix 2-1) will be used for this purpose. The Project Director must assign responsibilities and establish procedures to assure that a fully completed form is furnished the HSRI on-site Project Coordinator each week for the preceding week with a copy of all back-up Individual Work Sheets.

A separate Summary Sheet of Cost Data will be prepared for each quarter of the year as of September 30, December 31, March 31 and June 30, and will include completed Sections I and II.

The personnel data in the quarterly reports will be a summary of Section I of the 13 weekly reports covering that period. To assure uniformity of inclusive dates, the HSRI will indicate quarterly which 13 weekly reports will be covered in each quarterly report. The cost data in Section II will be for the inclusive dates of the respective quarter.

The quarterly Summary Sheet will be furnished the HSRI on-site Project Coordinator by the 12th day of the month following the end of the quarter (October 12, January 12, April 12, July 12).

Entry Instructions

(To understand the explanation on entries, it is imperative that the Summary Sheet be constantly in eyesight. A partially completed example is provided on page 27a)

Section I - Personnel Data

1. Periodicity

Check one, whether a weekly or quarterly, and fill in the inclusive dates which the report covers.

Appendix 4H

Entry Instructions - Project Summary Sheet of Cost Data

2. Category of Personnel

As indicated in the directions for preparation of the Individual Work Sheet (Job Title and Job Title Number Code) all personnel employed in the project must be categorized into the 24 categories and Job Title Code Numbers specified. Write-in options are provided in Job Title Code Numbers 4, 17, 22 and 24.

3. Base Data - Costs and Hours

Column 1: Number of Full Time Equivalents and Category of Personnel

This column represents the summation of all Individual Time Sheet data in "Total Hours Available This Week" converted into full time[1] equivalents for the categories of personnel utilized in the project and categorized into the 24 headings and numbers indicated. If, for example, 120 hours were reported by three physicians, this represents three full-time equivalent physicians (120 ÷ 40 = 3). If 100 hours were reported by five part time RN's, this represents 2.5 full time RN equivalents (100 ÷ 40= 2.5).

Column 2: Total Hours Per Week[2] Available for Work for Each Category of Personnel

This column represents the summation of all Individual Time Sheet - "Total Hours Available This Week", by category of personnel. If, for example, three physicians reported 120 hours available, 120 hours would be reported in column 2, line 5. (These are the total of hours that will be accounted for by major activity to obtain the percentages of personnel effort committed to each major activity.)

[1]Forty hour week equivalents

[2]This would be understood to mean "quarter" in the quarterly report

Column 3: Individual Weekly Rate of Compensation per Full Time Equivalent for Each Category of Personnel

Enter the weekly compensation rate per individual for each category of personnel. If salaries within categories vary, then an average salary rate for that category should be entered. If three physicians, for example, earn $550, $600 and $650 respectively, enter the average ($600) in column 3, line 5. (550 + 600 + 650 = 1800 ÷ 3 = 600).

Column 4: Total Weekly Personnel Costs - Each Category of Personnel

For each line (row) representing a category of personnel for which entries are made in columns 1 through 3, an entry will be made in this column by multiplying the number of full time equivalents (column 1) by the rate of individual compensation for each category of personnel (column 3).

Column 5: Hours Worked per Week by Category of Personnel

Enter the total hours worked for the week from all of the Individual Worksheets in the "Case-finding" activity for each category of personnel in which entries are reported in columns 1 through 4. (Comment: The row totals for each category of personnel, as reported in columns 5, 8, 11, 14, 17, 20, 23 and 26, must correspond to the total hours reported available for work in column 2. Columns 5 + 8 + 11 + 14 + 17 + 20 + 23 + 26 = column 2.)

Column 6: Percent of Total Hours Available for Work Performed in This Activity by each Category of Personnel

For each line (row) representing a category of personnel for which entries are made in columns 1 through 5, an entry will be made in this column by dividing the numbers of hours worked reported in column 5 by

the number of hours available for work reported in column 2. (Comment: Column 2 represents 100% for the row total: column 5 + column 2 = column 6; columns 6 + 9 + 12 + 15 + 18 + 21 + 24 + 27 = column 2 (100%)).

Column 7: Total Dollars Attributed to this Activity by Category of Personnel

For each row in which an entry was made in column 6, an entry will be made in this column by multiplying the dollar costs for each category of personnel indicated in column 4 by the percent indicated in column 6 (that part of the total of this category of personnel costs attributed to this major activity--case finding). (Column 4 x column 6 = column 7; column 7 + 10 + 13 + 16 + 19 + 22 + 25 + 28 = column 4)

Columns 8, 9 & 10 (Screening); 11, 12 & 13 (Diagnosis and Treatment); 14, 15 & 16 (Case-monitoring); 17, 18 & 19 (Health Education); 20, 21 & 22 (Other Experimental Activity); 23, 24 & 25 (Orientation and Staff Training) and 26, 27 & 28 (Management/Other Administrative Activities)

These additional seven sections (21 columns) representing major project activities will be completed in a manner similar to that described above for the section on Case-finding consisting of columns 5, 6 and 7.

The form indicates the respective column relationships to arrive at the appropriate percentages and personnel costs related to the various major functional activities.

Section II - Cost Data

Row - Direct Costs by Subsystem or Major Activity

The entries in the boxes in this row in columns 4, 7, 10, 13, 16, 19, 22. 25 and 28 are simply repetitions of the cost totals from the line (row) immediately above in the same columns. These are the totals of direct personnel costs by subsystem or major activity.

Row - Percent of Total Hours Available Committed to Each Major Activity

The entry in the box in column 2, this row, is simply a repetition of the entry from the total row in Section I in the same column representing the total number of hours per week available for work. This number, in this instance, constitutes 100% of the computations of all other sub-component entries in this row, The percentage entry in the box in column 6 of this row is the percentage that the number of hours from the entry on the total row in column 5 is to this overall total. (The total hours per week by the respective categories of personnel in the case-finding subsystem [entry in the Total row, column 5, Section I] as related to the overall total hours per week available for work [entry in the Total row, column 2, Section I] or [entry in Total row, column 5, Section I ÷ entry in Total row, column 2, Section I = percent of hours worked in the case-finding subsystem])

The entry in the box in this row in column 9 is similarly determined, i.e., entry in the Total row, column 8, Section I ÷ entry in Total row column 2, Section I = percent of hours worked in the screening subsystem.

The entries in the boxes on this row in columns 12, 15, 18, 21, 24 and 27 will be similarly determined.

The percent entries in all these boxes (8, 12, 15, 18, 21, 24 and 27) will total to 100%.

These percentages will determine the subsequent allocations of indirect costs.

Row - Other Direct Costs (Except Title XIX)

The project accounting system will categorize other direct costs (other than personnel costs) into the following accounts for reporting in this

system (internally, other more detailed accounts may be desired by the Project Director, but these must directly input into the following):

Supplies and Equipment

Including: Office equipment
Medical equipment
Office supplies
Medical supplies
Other office services (reproduction, etc.)

Transportation

Travel

It is assumed that these items and services are required for (requisitioned for or by) specific subsystem/major functional activities and that, therefore, funding in these categories is programmed quarterly for the fiscal year as is the accounting of expenditures.

Accordingly, the entries in the boxes in this row in columns 4, 7, 10, 13, 16, 19, 22, 25 and 28 will reflect the quarterly total expenditures for these "Other Direct Costs" by the subsystem or major function represented.

Row - Total Direct Costs (Except Title XIX)

The entries in the boxes in this row are simply the totals of the entries in two boxes above in the same columns--reflecting the total of Direct Costs (Personnel Costs) and Other Direct Costs.

Row - Total Indirect Costs

Row - Distribution Percentage

In the respective boxes in the "Distribution Percentage Row" simply repeat the percentages derived and reflected in the boxes in the respective column groups in the row - Percent of Hours Available Committed to each Major Activity. The percent entered in the box in this row in column 4 will be 100%, etc.

The project accounting system will categorize indirect costs into the following accounts for reporting in this system (internally, other more detailed accounts may be desired by the Project Director, but these must directly input into the following):

Utilities (Gas, electricity, Oil, Water)

Telephone

Transportation

Travel

Rent or depreciated and pro-rated building costs

Maintenance

Prorated costs of personnel employed in other activities but committing a percentage of their effort to the project

Other (Specify _____)

The entry in the box in column 4 (Row - Total Indirect Costs) will be the total of all indirect costs for the project for the quarter being reported. The entries in the boxes in this row in columns 7, 10, 13, 16, 19, 22, 25 and 28 will be the prorations of the total reflected in column 4, based upon the percentages reflected in these same columns on the row - Distribution Percentage.

Row - Total Direct and Indirect Costs (Except Title XIX)

The entries in the boxes in this row are simply the totals of the entries above in each respective column from the rows "Total Direct Costs" and "Total Indirect Costs".

Row - (Title XIX Costs) (Based on fixed fee/rates or sample data)

There are entry boxes in this row only for the screening and diagnosis and treatment subsystems. These data are to be utilized to estimate the

costs of the screening package as well as costs for diagnosis and treatment that were not otherwise previously reflected as direct costs.

These will primarily be in the category of private provider charges that are reimbursed under Medicaid (Title XIX).

If the private provider is reimbursed in the demonstration jurisdiction on a fixed fee basis for the screening package, the entry in the box in this row in column 10 would be this fixed fee multiplied by the number of screens completed by private providers in the quarter being reported upon. If a total package fixed fee is not utilized but a base fee with add-on costs allowable for specific components of the screen, it may be necessary to sample sufficient numbers of patient or provider profiles from the State Medicaid data tapes to compute the "average charge" for the screen and then use the average as the factor to be multiplied by the number of complete screens to make the entry in the box in column 10, this row. Whichever situation prevails, it is necessary that a footnote indicate the manner of ascertaining this cost.

The entry in column 13, this row, pertains to diagnostic and treatment charges reimbursed by Medicaid under Title XIX. Since, in only rare instances will a State or demonstration jurisdiction provide a data system that will feed back to the demonstration, private provider diagnosis and treatment costs related to problems found in screening, these charges (costs) will need to be estimated as an average per problem or an average per problem of specific categories. Data for computing these estimates will need to be based on sampling of State Medicaid files (provider payment tapes or patient profiles). Names of specific children screened in the demonstration, determined to have a problem requiring treatment,

and referred to a private provider for treatment may be tracked through Medicaid tapes in the ensuing several months to ascertain treatment provided and charges therefor. A sufficient sampling periodically may provide data for an appropriate average cost of diagnosis and treatment per problem found. Obviously, a more accurate figure would be based upon an average cost per type condition found, but this would require a fairly comprehensive system be developed for estimating costs. The cost for diagnosis and treatment (entry in box in column 13, this row) would be the "average factor" times the number of problems resolved (resolved through checking any one of the resolution options in Item 2 [case-monitor section] Problem Referral and Case-monitoring Sheet) during the report period.

The entry in column 4, this row, is the row total of columns 10 and 13.

Row - Total Direct and Indirect Costs (Including Title XIX)

The entries in these boxes in this row in the respective columns are the totals of the entries in these columns from the rows "Total Direct and Indirect Costs (Except Title XIX)" and "Total Direct and Indirect Costs (Including Title XIX).